**COVID-19 Health Questionnaire**

This questionnaire must be filled out in advance of attending NIBRT and sent to your NIBRT contact

Please sign below:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| **Question** | **Yes** | **No** |
| Do you have symptoms of cough, fever, high temperature, sore throat, runny nose, breathlessness or flu like symptoms now or in the past 14 days? |  |  |
| Have you been diagnosed with confirmed or suspected Covid- 19 infection in the last 14 days? |  |  |
| Are you cohabiting with or have you been in close contact of a person who is a confirmed or suspected case of Covid- 19 in the past 14 days? (less than 2m for more than 15 minutes accumulative in 1 day) |  |  |
| Have you been advised by a doctor to self-isolate at this time? Or are you waiting results of COVID 19 test? |  |  |
| Have you been advised by a doctor to cocoon at this time? |  |  |
| Have you travelled outside the Republic of Ireland in the last 14 days? |  |  |
| Are you in an at-risk group? (see definition on [www.hse.ie](http://www.hse.ie) for Very High or High Risk Groups) |  |  |

*The company is collecting this sensitive personal data for the purposes of maintaining safety within the workplace in light of the COVID-19 pandemic. The legal basis for collecting this data is based on vital interests and maintaining occupational health and will be held securely in line with our retention policy.*