SCE VISITOR SCREENING QUESTIONNAIRE

Name of Visitor

Phone Number of Visitor

Email Address of Visitor

Date of Visit

Name of Employee You Are Visiting

Email of Employee You Are Visiting

Location of Visit

Reason for Visit

Are you or anyone you are in close contact with experiencing the following symptoms**: Fever, Cough, Shortness of Breath**?

Yes

Have you or a member of your immediate household tested positive for COVID-19, are exhibiting symptoms of COVID-19 or been exposed to a person exhibiting the symptoms of COVID-19, or to a person that developed the symptoms of COVID-19 within 14 days of your exposure to that person, or did you or any member of your immediate household travel on a cruise, or through any international or high-risk domestic location?

Yes

Have you been exposed to anyone who has a confirmed case of COVID-19 or is suspected of having COVID-19?

Yes

Name Date

By providing my name on the line above, I certify that the above information is true and correct