**Please complete entire top portion of this form.**

**Date of visit:** Click or tap to enter a date.  **Site: Clearwater, FL**

**Visitor’s Name:**  Click or tap here to enter text.

**Company Name:**  Click or tap here to enter text.

**Please check any of the following symptoms you have had in last 5 days. If you do not have symptoms, please initial here \_\_\_**Click or tap here to enter text.**\_\_\_\_**

Fever (above 100.4) or Chills [ ]  Cough [ ]

Shortness of Breath [ ]  Difficulty Breathing [ ]

New Loss of Taste or Smell [ ]  Diarrhea [ ]

Fatigue [ ]  Muscle or Body Aches [ ]

Headache [ ]  Congestion or Runny Nose [ ]

Nausea or Vomiting [ ]

**Are you currently awaiting results from a COVID-19 test? Yes** [ ]  **No**[ ]

**Have you tested positive for COVID-19 in the past 5 days? Yes** [ ]  **No** [ ]

**Have you been diagnosed with COVID-19 by a**

 **licensed healthcare provider in the past 5 days? Yes** [ ]  **No** [ ]

**Have you been fully vaccinated? Yes** [ ]  **No** [ ]  **Opt Out**[ ]

**Visitors Signature:** Click or tap here to enter text. **Date:** Click or tap to enter a date.

**\*\*\* You may revoke your consent at any time by emailing back to the TM staff member who originated the document. \*\*\***

**This portion to be completed by Tampa Microwave host.**

**Host** Click or tap here to enter text. **Dept** Click or tap here to enter text.

**Reason for visit:** Click or tap here to enter text.

**Brief explanation of why it is on-site:** Click or tap here to enter text.

**Signature of TM Host:** Click or tap here to enter text.