**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.