COVID-19 NOVEL CORONAVIRUS

Please complete the following questions before beginning training today.

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Name:_								
Date:	Time:							
DO YOU HAVE THE FOLLOWING?								
			(30)					
		0011011	SHORTNESS	SORE	RUNNY	FEELING		
	FEVER	COUGH Yes□	OF BREATH	THROAT	NOSE	UNWELL		
	Yes□ No □	res□ No □	Yes□	Yes□	Yes□	Yes□		
			No □	No \square	No □	No □		
Yes □ No □	Have you been in close contact with someone who is sick or has confirmed COVID-19 in the past 14 days?							
Yes □	Yes \square Have you returned from travel outside of Canada in the past 14 days?							
No 🗆								
If you answered YES to any of these questions, go home & self-isolate right away. Visit OttawaPublicHealth.ca/coronavirus for more information as you may be eligible for a COVID-19 test.								
If feeling unwell, contact your health care provider or call Telehealth Ontario at 1-866-797-0000 to speak to a registered nurse.								
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Date:	Time:							
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						221		
		COUGH	SHORTNESS	SORE	RUNNY	FEELING		
	FEVER	Yes□	OF BREATH	THROAT	NOSE	UNWELL		
	Yes□ No □	No □	Yes□	Yes□	Yes□	Yes□		
			No □	No □	No \square	No □		
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