



**OCCUPATIONAL HEALTH AND SAFETY
MANAGEMENT SYSTEM**

**SURVEY ON HEALTH CONDITIONS OF
PROVIDERS AND VISITORS**

CODE	FOR-SST-03-00
DATE	08/05/2020
PAGE	1 OF 1

QUESTIONNAIRE FOR REPORTING RESPIRATORY AND OTHER CORONAVIRUS-RELATED SYMPTOMS

SUPPLIERS/CONTRACTORS

COMPANY NAME TO WHICH YOU BELONG:	DATE OF THE QUESTIONNAIRE: DD/MM/YYYY	
	ENTRY HOUR: 00:00 AM-PM	DEPARTURE HOUR: 00:00 AM-PM

SUPPLIER NAME: _____ **COMPANY:** _____

SUPPLIER'S ID NUMBER: _____ **EPS:** _____
ARL: _____

NAME AND PHONE NUMBER OF PERSON TO CONTACT IN CASE OF EMERGENCY

SURVEY	YES	NO	COMMENTS
WARNING SIGNS			
Have you had difficulty breathing or do you have a fever of 38°C or higher?			
RESPIRATORY SYMPTOMS	YES	NO	COMMENTS
Have you had a cough in the last few days?			
Have you had a sore throat in the last few days?			
Have you had contact with anyone diagnosed with coronavirus?			
Have you been tested for COVID-19?			
Have you been in contact with people diagnosed with COVID-19?			
Do you have any pre-existing conditions that are vulnerable to exposure to COVID-19: Diabetes, Cancer, Asthma, Pulmonary Fibrosis- COPD.			
Does anyone in your family have respiratory symptoms?			
Do you have personal protective equipment (gloves, mask)?			

TAKE INTO ACCOUNT THE DISTANCE THAT MUST BE KEPT FROM THE WORKERS INSIDE THE HOTEL

TEMPERATURE: _____

SIGNATURE AND ID OF THE PERSON WHO AUTHORIZES THE ENTRY _____

