



OCCUPATIONAL HEALTH AND SAFETY MANAGEMENT SYSTEM	CODE
	FOR-SST-03-00
SURVEY ON HEALTH CONDITIONS OF PROVIDERS AND VISITORS	DATE
	08/05/2020
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**QUESTIONNAIRE FOR REPORTING RESPIRATORY AND OTHER
CORONAVIRUS-RELATED SYMPTOMS**

GUESTS/CLIENTS

FULL NAME:	ISSUE DATE: DD/MM/YYYY
	ENTRY TIME: 00:00 AM-PM DEPARTURE TIME: 00:00 AM-PM

TYPE OF IDENTIFICATION: _____
IDENTIFICATION NUMBER: _____

PLACE OF PROVENANCE: _____

BIRTH DATE: 00/00/0000 **EPS:** _____ **INSUARANCE, ¿WHICH?:** _____

NAME AND PHONE NUMBER EMERGENCY CONTACT PERSON: _____

SURVEY	ENTRANCE		DEPARTURE		COMMENTS
	YES	NO	YES	NO	
WARNING SIGNS					
Have you had difficulty breathing, general discomfort or headache?					
RESPIRATORY SYMPTOMS					
Have you had: a cough, headache or fever 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?					



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Do you have any pre-existing conditions that are vulnerable to exposure to COVID-19: Diabetes, Cancer, Asthma, Pulmonary Fibrosis- COPD?					
Do you have the personal protection equipment (mask)?					
PREVENTION CARRIED OUT BY THE HOTEL	YES	NO	YES	NO	COMMENTS
Did someone take your temperature? Indicate the temperature status					
Did you wash your hands?					
Are you travelling from outside? If yes, please indicate from where.					
AUTHORIZATION OF ENTRANCE SIGNATURE					
GUEST SIGNATURE					