

Questionnaire visitor

PERSONAL INFORMATION

Name, First Name.....

address

.....

Phone-number. or email-adress:.....

INFORMATION ABOUT THE VISIT

Date and unit of the visit:

Name of the person visited:

Time from o'clock till o'clock

CONTROL 3G

Did you contract COVID-19 less than 6 months ago and have you recovered?

YES

NO

Have you been completely vaccinated against COVID-19 more than 14 days ago?

YES

NO

Did you test negative for COVID-19 less than 24 hours (rapid antigen test) or less than 48 hours (PCR test)?

YES

NO

If you were able to answer a question with YES, please have the relevant evidence ready for checking!

If you could not answer any of the questions with YES, please get tested for SARS-CoV-2 in the test center on the premises.

SELF-INFORMATION

1) Do you currently have acute cold symptoms of any severity with or without fever and / or loss of smell / taste?

YES

NO

2) Are you in quarantine due to your stay in a COVID-19 risk area?

YES

NO

3) Are you in a quarantine ordered by the health department?

YES

NO

4) if not vaccinated or not recovered:
Do members of your household have cold symptoms or are members of your household in quarantine?

YES

NO

If you answered YES to any of the statements, please contact the receiving employee directly.

.....
date, signature