Daily COVID-19 Attestation

Date of visit: _____ **Time:_____**

Location:_____ **Duration of visit:_____**

Name:_____

Affiliation / Company:_____

Phone / Text Number: _____

Are you experiencing any of the following symptoms?	**Yes**	**No**
Fever or feeling feverish	☐	☐
Sore throat	☐	☐
New cough (not related to chronic condition)	☐	☐
New nasal congestion or new runny nose (not related to seasonal allergies)	☐	☐
Muscle aches	☐	☐
New loss of smell	☐	☐
Shortness of breath	☐	☐
Please answer the following questions:	**Yes**	**No**
Have you been tested and had a positive result, or have you been told by a healthcare provider that you are likely positive for COVID-19?	☐	☐
Within the last 14 days, have you been in close contact with anyone that you know had been diagnosed with COVID-19 or had COVID-19 related symptoms?	☐	☐
Are you a health care worker who had contact with a COVID-19 positive individual as part of your work?	☐	☐
Do you agree to wear Personal Protective Equipment (PPE) while engaging in activities on campus or in MIT-affiliated facilities?	☐	☐
Do you agree to adhere to all rules and protocols of social distancing while engaging in activities on campus or in MIT-affiliated facilities?	☐	☐