

(YOUR COMPANY) is actively monitoring developments related to the COVID-19 coronavirus. We are taking proactive measures to protect the health and safety of our employees, contractors, and visitors.

The U.S. State Department and/or the Centers for Disease Control and Prevention has issued COVID-19 related travel alerts or designations of risk of community spread for a number of countries. Given the situation is evolving and in an abundance of caution, we ask that you kindly complete the questionnaire below. Please note that while you may decline to answer these questions, refusal will result in denied access to our office.

- | 1. In the last 14 days, have you visited the following countries? | <table border="0"> <thead> <tr> <th style="text-align: left;"><u>YES</u></th> <th style="text-align: left;"><u>NO</u></th> </tr> </thead> <tbody> <tr><td>China</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>South Korea</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Hong Kong</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Japan</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Italy</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Iran</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Singapore</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Thailand</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Taiwan</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Mongolia</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> <tr><td>Vietnam</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr> </tbody> </table> | <u>YES</u> | <u>NO</u> | China | <input type="checkbox"/> | <input type="checkbox"/> | South Korea | <input type="checkbox"/> | <input type="checkbox"/> | Hong Kong | <input type="checkbox"/> | <input type="checkbox"/> | Japan | <input type="checkbox"/> | <input type="checkbox"/> | Italy | <input type="checkbox"/> | <input type="checkbox"/> | Iran | <input type="checkbox"/> | <input type="checkbox"/> | Singapore | <input type="checkbox"/> | <input type="checkbox"/> | Thailand | <input type="checkbox"/> | <input type="checkbox"/> | Taiwan | <input type="checkbox"/> | <input type="checkbox"/> | Mongolia | <input type="checkbox"/> | <input type="checkbox"/> | Vietnam | <input type="checkbox"/> | <input type="checkbox"/> |
|--|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-------------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|-------|--------------------------|--------------------------|-------|--------------------------|--------------------------|------|--------------------------|--------------------------|-----------|--------------------------|--------------------------|----------|--------------------------|--------------------------|--------|--------------------------|--------------------------|----------|--------------------------|--------------------------|---------|--------------------------|--------------------------|
| <u>YES</u> | <u>NO</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| China | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| South Korea | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hong Kong | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Japan | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Italy | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Iran | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Singapore | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Thailand | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Taiwan | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Mongolia | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Vietnam | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 2. The CDC has provided the following list of symptoms associated with COVID-19: fever, cough, and shortness of breath. In the last 14 Days have you exhibited any COVID-19 Symptoms in general or since your travel return? | <table border="0"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> | | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. In the last 14 days, have you had <u>close contact</u> ¹ with anyone who visited any of the above listed countries in the last 30 days and who has exhibited any COVID-19 symptoms since their return? | <table border="0"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> | | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 4. Do you have, or have you had <u>close contact</u> in the last 14 days with anyone who, to your knowledge, had, a confirmed case of COVID-19? | <table border="0"> <tr> <td style="width: 100px;"></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table> | | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

Name: _____

Signature: _____

Date: _____

¹ Defined by Centers for Disease Control and Prevention (CDC) as:

- (a) Being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a health care waiting area or room with a COVID-19 case – or –
- (b) Having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on).