

Type of external party:
<input type="checkbox"/> Visitor / Supplier <input type="checkbox"/> Contractor

Please answer ALL questions below:	YES	NO	If 'Yes,' please specify.
1. Have you experienced any of the following symptoms in the last 14 days: severe difficulty breathing, severe chest pain, feeling confused or unsure of where you are, losing consciousness, fever and/or chills, cough, croup, shortness of breath**, decrease or loss of taste or smell*, extreme tiredness**, sore throat*, runny or congested nose, headache*, 'nausea, vomiting and/or diarrhea'***?			
2. In the last 10 days, have you been identified as a "close contact" of someone who currently has COVID-19 or is currently symptomatic (symptoms listed above)?			
3. In the last 10 days, have you received a COVID Alert exposure notification on your cell phone?			

I will adhere to Tiercon Corp.'s protocols such as:

- wearing the minimum PPE required (Tiercon provided face covering which varies based on the facility, safety glasses, safety shoes, Hi-Viz vest, and other PPE that applies to the work being conducted),
- maintaining physical distancing (6 ft. or greater) whenever possible,
- disinfecting touched surfaces, sanitizing my hands upon entry and after touching high-touch surfaces, and
- Notifying your Tiercon Corp. Contact if there are any changes to your health and/or personal circumstances that may/would impact the answers provided on this form.

By completing and submitting this form, you acknowledge that the information provided on this form are true and accurate.

Signature	
Printed Name	
Company Name	
Date	

Disclaimer: Having symptoms does not mean a person has COVID-19. All personal information will be kept confidential. This form needs to be completed for each visit.

*The symptoms have to be unusual and unrelated to getting a COVID-19 vaccine in the last 48 hours

**Not related to seasonal allergies, or other known causes or conditions you already have