WCAT Workers' Compensation Appeal Tribunal

# Visitor Screening Form

In an effort to reduce the risk of COVID-19 exposure, all visitors must complete the following screening questions.

Date: _____ Purpose of visit: _____

Name: _____ Time: _____

Company: _____ Phone: _____

Please mark either "yes" or "no" for the following questions.

| | Yes | No |
|---|---|---|
| 1. Do you have any of the following new or worsening symptoms: a fever, chills, cough, loss of sense of smell or taste, difficulty breathing, sore throat, loss of appetite, extreme fatigue or tiredness, headache, body aches, nausea, vomiting, or diarrhea? | ☐ | ☐ |
| 2. Have you had a fever, chills, cough, loss of sense of smell or taste, difficulty breathing, sore throat, loss of appetite, extreme fatigue or tiredness, headache, body aches, nausea, vomiting, or diarrhea within the last 10 days? | ☐ | ☐ |
| 3. Have you, or anyone you have had close contact with, travelled outside Canada within the last 14 days? | ☐ | ☐ |
| 4. Have you, or anyone you have had close contact with, been directed to self-isolate within the last 14 days? | ☐ | ☐ |
| 5. Have you, or anyone you have had close contact with, been tested for COVID-19 and are awaiting the results or have tested positive? | ☐ | ☐ |

I acknowledge that the above statements are true:

_____

Signature

**If you answer "yes" to any of the above questions, do not proceed to your hearing. Instead, contact your appeal coordinator for information on how to proceed.**