Columbia University
Health Screening Form

All visitors and vendors must fill out this form before entering Columbia University Buildings/Locations. This form must be returned to the primary contact person of your service contract.

Date: _____ **Company Name:** _____

Vendor/Visitor name: _____ **Tel No:** _____

University Contact Name: _____ **Building/Work Area:** _____

- **IMPORTANT NOTICE:** If you develop symptoms while on the premises, you must immediately leave the campus and contact your employer for appropriate guidance.

To the best of my knowledge, select any of the following*:

☐ 1. I have experienced any symptoms of COVID-19 in the past 14 days (fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, muscle pain, sore throat, abdominal pain/diarrhea, or new loss of taste or smell)

☐ 2. I tested positive for COVID-19 in the past 14 days

☐ 3. I knowingly have been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or who has or had symptoms of COVID-19 or have traveled to any of the states listed in Governor Cuomo's Executive Order 205-outside of clinical research, clinical care or clinical training

☐ 4. None of the above

- Should statements 1, 2, and/or 3 be checked you will not be allowed to enter any University building/location and you should immediately notify your employer.

To the best of my knowledge, I certify that the information submitted on this form is true and correct.

Visitor/Vendor Name printed:_____

Visitor/Vendor Signature: _____

*Questions are from the NY State Interim Guidance for Higher Education Research During the COVID-19 Public Health Emergency.

Source: *New York State Department of Health*

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