# Cpl Visitor Self-Assessment Form

The health of our employees, candidates, clients & visitors is our top priority. Cpl is committed not only to protect Cpl employees against COVID-19 but also to assist in the prevention of secondary transmission and international spread of the disease. Given the heightened concerns about the risk of COVID-19 spreading, we are asking all visitors to perform a self-assessment when entering Cpl offices.

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| **Visitor/Contractor COVID-19 Questionnaire** |
| Visitor’s Name:  |  |
| Visitor’s company:  |  |
| Contact Number:  |  |
| Visiting:  |  |
| Date:  |  |

**Please circle your answers below:**

|  |  |  |
| --- | --- | --- |
|  | Have you visited any countries outside Ireland in the last 14 days?  | Yes/No |
|  | Are you suffering any flu like symptoms/symptoms of COVID-19? | Yes/No |
|  | Within the last 14 days, have you been in close contact with a person confirmed to have a novel COVID-19 infection or who is under quarantine because of a suspected case of COVID-19?  | Yes/No |
|  | Have you been in contact with someone who has visited an affected region in the past 14 days? |  |
|  | Do you have a cough, cold, fever-like temperature shortness of breath, difficulty breathing, sore throat, diarrhea, tiredness or aches, pains, loss or change to sense of smell or taste  | Yes/No |
|  | Have you consulted a Doctor or other medical practitioner? | Yes/No |
| **NOTE:** Please adhere to Cpl’s office standard processes/procedures regarding infection control, i.e. hand washing/hand sanitising and general coughing/sneezing etiquette. |
| **Visitor Signature:**  | **Date:**  |

If you answered yes to any of questions above or you do not wish to fill out this questionnaire, you will not be permitted to remain in Cpl’s office. We will reschedule the meeting and/or make other arrangements.

If you are experiencing any of the symptoms mentioned above, seek medical advice right away. Before visiting a doctor’s office or emergency room, phone ahead and inform them of your recent travel and/or your symptoms.

By signing the below, you certify that you have answered the above questions to the best of your knowledge. Provided it is required by applicable law, you consent for Cpl to collect and process your personal information contained in this questionnaire to assist with possible contact tracing.

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**Print Name**: **Date:**

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**Signature (Visitor):**

**Privacy notice:** Cpl collects this information on an exceptional basis to protect its employees, contractors and visitors. The information contained in this questionnaire will be retained for up to 14 days.

**Access to Cpl office** (circle one):

**Approved Denied**