COVID-19 Mandatory Health Declaration

First Name: _____ **Surname:** _____ **Project:** _____

Employer: _____ **Date:** _____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS?

- ☐ **Fever**
- ☐ **Cough**
- ☐ **Shortness of breath**
- ☐ **Sore Throat**
- ☐ No Symptoms

Have you returned from any overseas country in the past 14 days?

- ☐ **Yes**
- ☐ No

In the past 14 days, have you been in close contact with anyone who has been diagnosed with COVID-19?

- ☐ **Yes**
- ☐ No

If you ticked any of the above symptoms (fever, cough, shortness of breath, sore throat), or **YES** to any of the above questions:

- You are not allowed to sign on or start work.
- Contact a health care professional for advice.
- Speak to your employer about your working arrangements.

I declare that the information that I have provided is true and correct.

- ☐ Yes

SIGNATURE

Signed:

By completing this questionnaire, I hereby consent to CPB collecting, using and disclosing my personal information for the purpose of preventing or managing the risk and/or reality of COVID-19 in the workplace and in compliance with the Privacy Act 1988 (Cth) and CIMIC Group's Privacy Policy.