

EMPLOYEE HEALTH DECLARATION FORM



Employee Name:	
Company:	ALFA LAVAL OCEANIA
Alfa Laval site:	

HEALTH DECLARATION: By completing this form, I consent to Alfa Laval collecting, using and storing my personal information for the purpose of compliance with Alfa Laval and any Local, State or Federal Government's or properly constituted authority's, policies, procedures, directions, laws or regulations.

INSTRUCTION TO EMPLOYEE:

1. If **ANY** answer is **YES – STOP**. Refer to Alfa Laval COVID-19 policy, section 3.0
2. If **ALL** answers are **NO – CONTINUE**.

QUESTIONS	Circle Answer	
	YES	NO
I am a confirmed case of COVID-19 (Coronavirus).	YES	NO
In the last 14 days, I have had close contact with a confirmed case of COVID-19 (Coronavirus).	YES	NO
In the last 14 days, I have returned from ANY overseas destinations.	YES	NO
In the last 14 days, I have had close contact with someone who has returned from ANY overseas destinations in the last 14 days.	YES	NO
In the last 14 days, I have had close contact with someone with flu-like symptoms (i.e. fever, cough, sore throat, runny nose, fatigue, difficulty breathing).	YES	NO
<p>I am suffering from symptoms flu-like symptoms (or in the last 48 hours), which may include:</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> Sore-throat</p> <p><input type="checkbox"/> Running nose or Stuffy nose</p> <p><input type="checkbox"/> Headache, Aches and pains</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Breathing difficulty</p> <p>OR any other symptoms (i.e. gastroenteritis related or similar) that may put our employees or other people at risk.</p>	YES	NO

I declare that all the information given in this form is true and correct:

Employee Name:	Signature:	Date:
Manager Name:	Signature:	Date: