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Surname, First name _____ Birthday (Day/Month/Year)_____

Occupation _____

Telephone number _____

Please fill the form for the medical history. By signing the form you consent to to processing of your personal data and information provided below.

You will only be contacted by phone in case of a positive COVID-19 test result. Hence, please specify a reachable telephone number in the questionnaire.

You will be **NOT** notified in case of a negative result.

Please indicate the reason(s) for the COVID-19 swab test and check all that apply:

1. □ I had contact with a person tested positive for COVID-19

On _____ (date) for _____minutes/_____hours.
In a distance of _____ metre(s), □ outdoor □ in a closed room
□ I was wearing a mask □ The positive tested person was also wearing a mask
□ I was notified by the "Corona Warn-App" that I had contact with a person who is tested positive

Please note: A swab test is only diagnostically conclusive when the contact happened more than 5 days ago!

2. □ I am coming from a designated international risk area _____ (name of the country/area)

Please present the proof/confirmation of the stay abroad!

3. □ I have a Certificate of Eligibility ("Berechtigungsschein") for a test from a public health authority

4. □ I work in the healthcare

Please present the proof of employment!

5. □ I need a negative COVID-19 test result for being admitted to a hospital or rehabilitation facility

Please present the written requirement from the facility!

6. □ My symptoms started from _____ (date)
My symptoms are the follows: _____
_____
_____
_____

7. □ I need a medical certificate of incapacity for work ("Arbeitsunfähigkeitsbescheinigung")

_____ _____
Place, Date Signature