COVID-19 Pandemic – Self -Declaration Date: _____

Our facility is under the jurisdiction of the City of Toronto Public Health. We are taking all safety precautions to reduce the risk of spread of COVID-19 and expect you to follow Public health Directives as well. When present on campus there is an increased risk of contracting COVID-19. This risk will be no greater than going to the grocery store, the mall, or a restaurant. All personnel will be wearing adequate PPE throughout testing and all equipment/surfaces will be disinfected between participants in order to mitigate this risk.

All participants will:

1. be required to wear a face covering when entering the building, during the registration, while waiting and during select tests
2. sanitize their hands at the registration area
3. be required to wear a long sleeved t-shirt and fitted basic working or gardening gloves during the performance of the aerobic fitness test and job simulation tasks

This disclosure form seeks information from you that we must consider before the testing gets underway. Everyone is at risk for contracting COVID-19. However, certain medical conditions including, but not limited to, diabetes, asthma, COPD, cancer treatment, heart disease and high blood pressure may result in more serious consequences if COVID-19 is acquired. It is essential that you disclose any medical conditions and understand that some conditions may make you ineligible to undergo testing. Please answer the following questions:

Question	**Yes**	**No**
Have you received the first dose of a COVID-19 vaccine? Date: (dd/mm/yyyy)		
Have you received the second dose of a COVID-19 vaccine? Date: (dd/mm/yyyy)		
Have you received the booster or third dose of a COVID-19 vaccine? Date: (dd/mm/yyyy)		
You must provide proof (eg QR code) of your vaccination status at the registration desk		
Are you experiencing shortness of breath or have trouble breathing?		
Are you experiencing tiredness?		
Are you experiencing chest pain?		
Did you recently develop a persistent dry cough?		
Did you recently develop a persistent runny nose or nasal congestion?		
Have you recently lost or had a reduction in your sense of taste and/or smell?		
Do you have a sore throat?		
Have you been in contact with someone who has tested positive for COVID-19? Date: (dd/mm/yyyy)		
Have you tested positive for COVID-19? Date Tested: (dd/mm/yyyy)		
Have you been tested for COVID-19 and are awaiting results? Date Tested: (dd/mm/yyyy)		
Have you travelled outside of Canada in the past 14 days? Date: (dd/mm/yyyy)		
Have you attended a large group gathering (more than 10 persons) in the past 14 days?		

By signing this document, I acknowledge that the answers I have provided above are true and accurate. I also understand that my contact information will be used for contact tracing purposes in the event of a COVID-19 incident.

Print Name: _____ Date: _____

Signature: _____

Email: _____

Phone: _____