COVID-19 Report Form（for close contact）

|  |  |
| --- | --- |
| Date  | mm/ dd/ yyyy |
| Department/Faculty |  |
| Position/Student Number |  |
| Name |  |

Please describe the following: please fill in the boxes below to the best of your ability.

|  |
| --- |
| 1. ① Circumstances of contact with COVID-19: ( when and how? )
 |
| ② Your condition after contact: (symptoms, body temperature) |

If you have any additional information other than that mentioned above, please write and attach as additional pages to this form.