



To help prevent the spread of COVID-19 and reduce the potential risk of exposure to our employees and visitors, we are conducting a simple screening questionnaire. Your participation is important to help us take precautionary measures to protect you and everyone in our office.

Name (printed): _____ Cell Phone: _____

Organization/Business: _____ Email: _____

Reason for visit and date: _____

SECTION 1: Health Status Self-Declaration by Visitor (circle Yes or No)

Have you had close contact with or cared for anyone diagnosed with COVID-19 within the last 14 days?	Yes No
Are you showing any signs of one or more of the following symptoms or have you been exposed to anyone showing these signs: temperature >100.4°F (>38°C) or higher, cough, shortness of breath, difficulty breathing, loss of taste or smell, tiredness?	Yes No

SECTION 2: COVID-19 Vaccination Confirmation by Visitor

As part of our efforts to provide a safe workplace and in accordance with county guidelines, the North Carolina Board of Pharmacy requires all visitors to wear face coverings while in our office.

PLEASE SELECT ONE:

☐ I am fully vaccinated. (Please show your vaccination card or a photo of it to a staff member.)

☐ I do not have proof of vaccination or I decline to answer.

Signature of NCBOP staff member: _____ Date: _____