**Columbia University Facilities and Operations**

**Health Screening Form**

*All visitors and vendors must fill out this form before entering Columbia University Buildings/Locations. This form must be returned to the primary contact person of your service contract.*

<table>
<thead>
<tr>
<th>Date: ______________________________</th>
<th>Company Name: ______________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vendor/Visitor name: __________________</td>
<td>Tel No: ______________________________</td>
</tr>
<tr>
<td>University Contact Name: ______________</td>
<td>Building/Work Area: ____________________</td>
</tr>
</tbody>
</table>

- **IMPORTANT NOTICE:** If you develop symptoms while on the premises, you must immediately leave the campus and contact your employer for appropriate guidance.

---

**To the best of my knowledge, select any of the following:**

- You have experienced any symptoms of COVID-19 in the past 14 days (fever, cough, shortness of breath or difficulty breathing, chills, repeated shaking with chills, muscle pain, sore throat, abdominal pain/diarrhea, new loss of taste or smell, or other symptoms of COVID-19).
  - I have been cleared by a healthcare provider, Human Resources or Leave Management to come to campus
  - I have not yet been cleared by a healthcare provider, Human Resources or Leave Management*
  - I have only fatigue, headache, and/or muscle/joint aches that began within 2 days of COVID vaccination and lasted for 3 days or less AND I feel well enough to work

- You knowingly have been in close or proximate contact in the past 14 days with anyone who has tested positive for COVID-19 or who has had symptoms of COVID-19
  - I have been notified by a contact tracer that I am a close contact and am following quarantine guidance*
  - I have NOT been identified as a close contact (within 6 feet for more than 10 mins) requiring quarantine
  - I am fully vaccinated (more than 2 weeks after the second dose for 2-dose vaccines; more than 2 weeks after vaccination for 1-dose vaccines), and have no symptoms

- You tested positive for COVID-19 in the past 14 days*
  (Please check all that apply if you have tested positive for COVID-19 in the past 14 days)
  - More than 10 days have passed since onset of symptoms or the date of the positive test
  - I have had no fever within the past 24 hours without the use of fever-reducing medications
  - My other symptoms have improved
*Should these statements be checked, you will not be allowed to enter any University building/location and you should immediately notify your employer.

To the best of my knowledge, I certify that the information submitted on this form is true and correct. Furthermore, I agree to follow all Columbia University safety protocols which currently include wearing face coverings indoors.

Visitor/Vendor Name (Printed): ____________________________________________________________

Visitor/Vendor (Signature): ______________________________________________________________

Questions are from the NY State Interim Guidance for Higher Education Research During the COVID-19 Public Health Emergency.

Source: New York State Department of Health