

Alternative Therapeutic & Nutritional Consultants LLC
Dr. Alan Shair
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Piscataway, NJ 08854

COVID-19 SCREENING TOOL

1. Have you experienced any respiratory symptoms (cough, sore throat, congestion) in the last 48 hrs?
a. Yes___ b. No___

2. Have you experienced a fever in the last 48 hours?
a. Yes___ b. No___

3. Have you traveled outside of the state of New Jersey in the last 14 days? If yes which state(s)? _____
a. Yes___ b. No___

4. Have you traveled outside of the United States in the last 14 days?
a. Yes___ b. No___

5. Have you been in contact with anyone who has traveled outside the United States in the past 14 days?
a. Yes___ b. No___

6. Have you had contact with anyone who has pending results or tested positive for COVID-19?
a. Yes___ b. No___

Name_____

Date_____

Signature:_____

***This form is to be completed by visitors upon arrival at the office at every visit.**