

Campus Visitor Check – In Form University of Charleston

Arrival Time: _____

Departure Time: _____

Date of Visit: _____

Full Name: _____

Contact Number: _____

Email Address: _____

Organization Name: _____

Area/Department Visited: _____

Reason for Visit: _____

Are you vaccinated against COVID-19? If so, please submit proof of your vaccination record to the University.

Yes No

According to the U.S. Centers for Disease Control and Prevention & the World Health Organization, COVID-19 Symptoms include:

- | | | |
|---|----------------------|------------------------|
| * Fever or chills | * Cough | * Muscle or body aches |
| * Shortness of breath or difficulty breathing | * Fatigue | * Headache |
| * New loss of taste or smell | * Diarrhea | * Sore Throat |
| * Congestion or runny nose | * Nausea or vomiting | |

Are you experiencing any of the following symptoms listed above?

Yes No

Are you living with or caring for an individual who is suspected or a confirmed case of COVID – 19?

Yes No

Have you been in contact with anyone known or suspected to have COVID - 19 in the last 14 days?

Yes No

Have you tested positive for COVID-19 within the last 30 days?

Yes No

I certify all the information provided is shared to the best of my ability.

Signature

Date

You are required to do the following while you are on campus:

- ✓ Physical distance
- ✓ Wear a mask at ALL times when you are on campus if you are not vaccinated
 - Your mask should be fitted properly on your face
- ✓ Wash your hands often
- ✓ Use hand sanitizer as needed
- ✓ Disinfect your work area
- ✓ **If you are having lunch without a mask, it is important to continue physical distancing**
- ✓ Please follow all UC policies and safety compliance instructions per the CDC

Thank you for helping the University do everything we can to make sure our UC community safe.

Please return this completed form to COVID-19@ucwv.edu email address.