I, , have read the guidance provided to me by University of North Texas System College of Pharmacy (the College) and the rotation site on . I attest upon my fiduciary responsibility as a student at the College that all of the below information is true and correct to my knowledge.

I understand that as the COVID-19 situation progresses, my preceptor and Experiential Faculty at the College will notify me with new information and guidelines as they are made available for my safety and the safety of others. I also understand that travel restrictions to certain locations may be added or changed, and I will speak with my preceptor about any future changes.

I understand that if I contract or am exposed to a suspected or confirmed case of COVID-19, I will alert my preceptor and the College (Lisa.Worrall@unthsc.edu) within 24 hours in addition to guidelines set by the site and the College. If any of the answers below change, I will alert the Experiential Faculty and my preceptor and will not attend rotation until clearance is given by my preceptor.

Please indicate yes or no to the below statements:

Travel

Within the last 14 days, I have traveled outside of the Dallas-Fort Worth Metroplex area (or the area I am completing my current rotations in.

◯ **Yes** ◯ **No**

If yes, where? Location

Exposure

I have been in close contact with a person with suspected or confirmed COVID-19 during the previous 14 days.

◯ **Yes** ◯ **No**

If yes, note date and location.

*Close contact is defined as: a) being within approximately 6 feet (2 meters) of a COVID-19 case; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case or b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on).

Illness

I have shown symptoms of respiratory illness (e.g. cough or shortness of breath) in the last 14 days

◯ **Yes** ◯ **No**

I have had a fever of 100.4 degrees F or higher in the last 14 days.

◯ **Yes** ◯ No

Rotation Dates:

Preceptor Name and Site Location:

By signing this form, I attest I have read the above information and provided truthful answers.

Signature: **Date:**