COVID-19 Self Declaration

Within the last 14 days, have you received a confirmed diagnosis for coronavirus (COVID-19) by a coronavirus (COVID-19) test or from a diagnosis by a health care professional or are you waiting for a pending COVID-19 test result?

☐ **YES** ☐ **NO**

In the last 14 days, have you had close contact with or cared for someone diagnosed with COVID-19 or are you participating in a COVID-19 clinical study that includes being exposed to the virus?

☐ **YES** ☐ **NO**

In the last 14 days, have you experienced any cold, flue-like symptoms (to include fever, cough, shortness of breath or difficulty breathing, sore throat, pressure in the chest extreme fatigue earache, persistent headache, diarrhoea, vomiting, muscle pains, chills, repeated shaking with chills and persistent loss of smell or taste)?

☐ **YES** ☐ **NO**

If you answer "**YES"** to any of these questions, access to the studio will be postponed.

By signing this release, I c certify that my answers are corrected complete to the best of my knowledge and I acknowledge that I understand its content and that I voluntarily agree to its terms and that this release cannot be modified orally.

DATE	TEMPERATURE	NAME	SIGNATURE