

<p>Were you tested positive for the infection with SARS-CoV-2?</p> <p>If yes, please, provide the date</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Date of receiving a positive test result</p>
<p>Have you been in contact with a person who was tested positive for SARS-CoV-2 infection or with anyone with symptoms of Covid-19?</p> <p>If yes, please, provide the date</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Date of contact</p>
<p>How long was the time of contact with the SARS-CoV-2-infected person?</p>	
<p>What was the distance between you and the SARS-CoV-2-infected person?</p>	
<p>Did you wear a face mask or a face shield during the above contact?</p>	
<p>Please, provide the name and contact details of the person who may receive the information about you, in case of emergency (name, phone number)</p>	

Lublin, date

Signature