VERIFICATION STATEMENT

By signing below, I certify that I have not had contact with anyone who received a COVID-19 diagnosis or was suspected of having a coronavirus infection within the last 14 days. I further certify that, within the last 24 hours, I have not experienced chills, shortness of breath, or a loss of taste or smell.

Printed Name | Signature | Date

_____ | _____ | _____

Home Address | Phone Number

_____ | _____