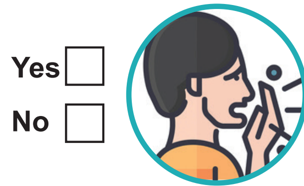
Self-Assessment

Have you experienced any of the following symptoms in the past 48 hours that are unusual for you:

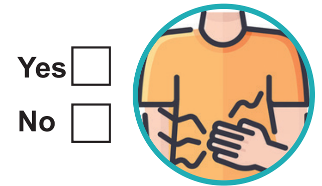
Yes ☐ No ☐

Fever or chills

Yes ☐ No ☐

Cough

Yes ☐ No ☐

Sore throat

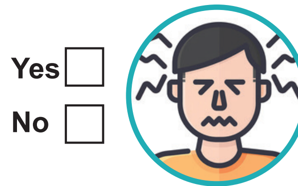
Yes ☐ No ☐

Nausea or vomiting

Yes ☐ No ☐

Congestion or runny nose

Yes ☐ No ☐

Fatigue

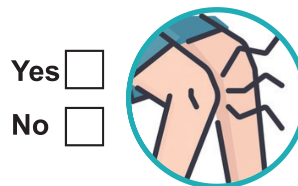
Yes ☐ No ☐

Headache

Yes ☐ No ☐

Shortness of breath or difficulty breathing

Yes ☐ No ☐

New loss of taste or smell

Yes ☐ No ☐

Muscle or body aches

Yes ☐ No ☐ Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have laboratory-confirmed COVID-19 or with anyone who has any symptoms consistent with COVID-19?

Yes ☐ No ☐ Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?

Yes ☐ No ☐ Are you or anyone in your household currently waiting on the results of a COVID-19 test?

Did you answer **NO** to ALL QUESTIONS?
APPROVED. Thank you!

If you answered **YES to ANY QUESTIONS**, **please contact Summit Staff**

ENDEAVOR BUSINESS MEDIA