Failure to complete all sections could result in a delay of processing your specimen.

Name:_____ Date of Birth:_____

Today's Date:_____ Who is your primary care provider? _____

Phone number we can reach you at with results: _____

Alternate name and contact number:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Type of insurance (we will need to see the card or a copy) _____

Please Circle all that apply:

Fever Tiredness Aches and Pains Diarrhea

Headache Chest pain or Pressure Sore Throat Cough

Loss of taste or smell Shortness of breath Exposure to someone who is positive

General Exposure Testing for peace of mind Other:_____

Date of onset of above symptoms:_____

Please check (ONLY 1) which best describes your situation:

_____**Symptomatic healthcare worker**

_____**Symptomatic patients in long-term care facilities** (nursing home/assisted living)

_____**Symptomatic and over age 65**

_____**Symptomatic with underlying conditions** (lung issues, heart issues, immunocompromised)

_____**Symptomatic first responders** (Emergency Medical Technicians (EMTs), paramedics, firefighters, and police officers)

_____**Symptomatic critical infrastructure workers** (Federal, state, & local law enforcement, 911 call center employees, Fusion Center employees, Hazardous material responders from government and the private sector, Janitorial staff and other custodial staff, Workers – including contracted vendors – in food and agriculture, critical manufacturing, informational technology, transportation, energy and government facilities

_____**Healthcare or first responder with no symptoms**

_____**Symptomatic individual that doesn't fall in above category**

_____**Individuals with mild symptoms in hot zone communities**

_____**Other:_____**