Observer Information & Agreement

General Information: (Please Print)

Name _____

Permanent Mailing Address

_____

_____

Email _____ Local telephone number _____/_____

Emergency contact _____ _____

Observation Hours Requested

□ PT □ OT □ SLP □ Other _____

Confidentiality Agreement:

I understand that I am committed to an oral and written bond regarding the confidentiality of each patient's medical and personal information with which I may come in contact during the course of my work. I will not release any patient information to my family, friends or anyone else.

Signature _____Date _____/_____/_____

Earl R. Wilson, Founding Chairman
METHODIST
REHABILITATION CENTER

Do you have any of the following symptoms? (check all that apply)

o None of these	o Severe headache	o Dry Cough	o Runny Nose
O Reduction in sense of smell	o Shortness of breath	o Fever or above your normal temperature	O Sore throat

1. Have you tested positive for COVID 19?
   Yes ____ No _____
2. Have you been tested for COVID 19 and are awaiting results?
   Yes ___ No _____
3. Have you been in contact with someone who has tested positive for COVID 19?
   Yes _____ No ____
4. Have you traveled outside the US by air or cruise ship in the past 14 days?
   Yes _____ No _____
5. Have you traveled within the US by air, bus, subway, or train within the last 14 days?
   Yes _____ No _____

By signing this document, I acknowledge that the answers I have provided are true and accurate. I understand the serious nature of this pandemic and will fully comply with all procedures required of me by MRC.

Employee Signature: _____ Date: _____Time:_____

MRC RN Signature _____ Date: _____ Time:_____

Rev 4/2020