

Atlantic County
Meadowview Nursing and Rehabilitation Center

OUTDOOR VISITATION ATTESTATION FORM

By completing and signing this attestation form, you confirm that you have read and reviewed the procedures provided which are required for outdoor visitation with residents of this facility.

Your Name: _____

Name of resident you are visiting: _____

Today's Date: _____

Contact Phone Number: _____

I certify that I do not have any of the following symptoms:

- Fever
- Cough
- Shortness of Breath
- Sore Throat
- Muscle or body ache / pains
- Chills
- Fatigue
- New loss of taste or smell
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

I also certify:

- I have not been in close contact **within the last 14 days** with anyone who is ill with respiratory illness.
- I have not been in close contact **within the last 14 days** with anyone with a confirmed diagnosis of Corona Virus disease 2019 (COVID-19) or who is under investigation for COVID-19.
- I have not traveled outside the country **in the last 30 days**.
- I do not reside in or regularly travel to a town where community-based COVID-19 is occurring.

I understand that:

- I will have to follow proper handwashing procedures; I will have to practice social distancing, have no physical contact and remain six feet apart; and I must wear a face covering while on site.
- I am aware of the possible dangers of exposure to COVID-19 and agree to follow the rules of the facility.
- I will notify the facility if I test positive for COVID-19 or exhibit symptoms of COVID-19 within 14 days of today's visit.

Visitor Signature and Date: _____

Resident Signature and Date: _____