**ZICA CONTACT TRACING FORM**

**1** Have you visited any country where COVID-19 has been reported in the last 1

**2** If YES select which one, tick the country/ices visited

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| China | ☐ | Malaysia | ☐ | Cambodia | ☐ | USA | ☐ | Spain | ☐ | Israel | ☐ | Oman | ☐ | | |
| South Korea | ☐ | Singapore | ☐ | Thailand | ☐ | Canada | ☐ | Belgium | ☐ | Bahrain | ☐ | Egypt | ☐ | | |
| Iran | ☐ | Australia | ☐ | India | ☐ | Germany | ☐ | United Kingdom | ☐ | Afghanistan | ☐ | Iraq | ☐ | | |
| Japan | ☐ | Vietnam | ☐ | Nepal | ☐ | France | ☐ | Sweden | ☐ | UAE | ☐ | Lebanon | ☐ | | |
| Italy | ☐ | Phillippines | ☐ | Sri Lanka | ☐ | Russia | ☐ | Finland | ☐ | Kuwait | ☐ | Other (specify) | | | |

**3** Did you have any contact with COVID-19 case while you were in COVID-19 affected country? ☐ Yes ☐ No

**4** Last exit date from COVID-19 affected country? _____

**5** Please specify the specific province/city you have been in the last 14day? _____

**6** Lastname _____ Firstname _____

Middlename _____ Age _____

Sex ☐ Male ☐ Female National Registration Card/ Passport _____

**7** Address in Zambia _____

Mobile Phone _____ Email _____

**8** Clinical information Have you had any of the following symptoms

Fever ☐ Cough ☐ Difficulty breathing ☐ Sore throat ☐ Headache ☐ Other (specify) _____

**9** Please indicate which Person you have come into contact whilst being served at ZICA. Tick the boxes below

| **ZICA Work Sections** | | **Name of ZICA Officer** |
|---|---|---|
| CEO and CEO's Secretary | ☐ | _____ |
| Directorate - Standards & Regulation | ☐ | _____ |
| Directorate - Membership | ☐ | _____ |
| Directorate - Finance | ☐ | _____ |
| Directorate - Education | ☐ | _____ |
| Finance | ☐ | _____ |
| Membership | ☐ | _____ |
| Education | ☐ | _____ |
| Standards | ☐ | _____ |
| Library | ☐ | _____ |
| Reception | ☐ | _____ |
| Security | ☐ | _____ |
| IT | ☐ | _____ |
| Human Resource | ☐ | _____ |
| Procurement | ☐ | _____ |
| Practice Review | ☐ | _____ |
| Examination | ☐ | _____ |
| Stores | ☐ | _____ |

**This form should be left at the reception or the last officer in contact with.**

**10** Declaration

I hereby declare that the information given above is true and correct:

Signature _____ Date (DD/MM/YYYY) _____

**To be completed by Entry Health Screener**

**10** Measured Temperature _____ Screening outcome ☐ Released ☐ Referred for further assessment

Completed by (Name) _____ Date _____ Signature _____