



Catholic Health Services

VISITOR ACKNOWLEDGEMENT FORM

I, _____ acknowledge the following:
(print name)

- I have watched and understand the Infection Control videos and agree to abide by the Facility's Infection Control Protocols and Instructions at all times.
- I have been provided with a copy of the Governor's twelve page document entitled "Task Force on the Safe and Limited Re-Opening of Long Term Care Facilities."
- I am familiar with the COVID-19 symptoms and I attest that at any time I enter the Facility I am free of symptoms and I have not within 14 days knowingly been in contact with any person who is positive.
- If requested by the Facility, I agree that I will take a Facility provided COVID-19 test and await the negative test results before I am permitted to enter the Facility.
- If within 14 days of visiting the Facility I am diagnosed with COVID-19 or there is a change in my medical condition, I will notify the Facility immediately.
- I understand the risks and consequences to myself, the residents and staff of visiting during a National Healthcare Emergency. I understand and agree that at all times that I am visiting the Facility, I must wear the protective personal equipment ("PPE") provided by the Facility. Furthermore, I understand the PPE will be discarded when I leave the Facility.
- I understand that Facility may restrict or revoke visitation if I fail to strictly follow its infection prevention or other COVID-19 rules.
- I agree to defend, indemnify and hold the Facility harmless from any claims should I contract COVID-19 or if I infect anyone at the Facility.
- I have been given the opportunity to ask any questions and seek further information and all my concerns have been fully and adequately addressed.
- This acknowledgement shall remain in effect for all visits to the Facility.

Signature of Visitor _____ Date _____

Signature of Facility Screener _____