

COMMUNITY CENTRES AND HALLS ENTRY FORM



pmhc.nsw.gov.au

REGISTRATION

DATE	
NAME	
ADDRESS	
MOBILE PHONE NUMBER	

1. Do you have any of the following symptoms: fever, cough, runny nose, shortness of breath?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
2. Have you been in contact with a person confirmed sick with COVID-19?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
3. Have you returned from interstate or overseas in the last 14 days?	YES <input type="checkbox"/>	NO <input type="checkbox"/>
4. Have you been diagnosed with COVID-19?	YES <input type="checkbox"/>	NO <input type="checkbox"/>

This information supplied will be kept for a period of at least 28 days, is used only for the purposes of tracing COVID-19 infections and will be stored confidentially and securely.