Health Declaration Form- COVID-19

Required to be submitted for every patient who is scheduled at Rose City Dental.

I, (last, first name) ____,

hereby certify, represent and warrant as follows:
Within the twenty one (21) days immediately preceding the Date of this Health Declaration Form ("Declaration"), I HAVE NOT:

1. tested positive or presumptive positive with the Coronavirus or been identified as a potential carrier of COVID-19 virus or similar communicable illness ("Coronavirus");

2. experienced any symptoms commonly associated with the Coronavirus by a recognized health or regulatory authority, such as a country for which the Center for Disease Control and Prevention ("CDC") issued a Level 3 Travel Advisory for Corona;

3. been in any location positively designated as hazardous and/ or eventually infected with Coronavirus by a recognized health or regulatory authority, such as county for which the Center for Disease Control and Prevention ("CDC") issued a Level 3 Travel Advisory Coronavirus;

4. been in direct contact with or the immediate vicinity of any person I knew and /or now know to be carrying the Coronavirus or has been identified as a potential carrier of Coronavirus.

I CAN account for all location visited over the previous twenty-one (21) days and shall provide an exhaustive list of all location visited and modes of transportation IF REQUESTED.

EMAIL Address for contact tracing if needed : ____

I AGREE to notify Rose City Dental (by email to drtaerosecitydental@gmail.com) of any change in status, including diagnosis with Coronavirus and/or quarantine, within thirty (30) days either before or following a dental appointment.

I WILL If asked, wear a mask (of the specifications recommended by the doctor while entering and exiting the operatory) and /or any relevant public authority.

I WILL consent to having my temperature taken by any representative of Dr. Tae Lee prior, during and after dental appointment as requested.

I ACKNOWLEDDGE and ACCEPT that this Declaration shall be governed by laws of Oregon. I irrevocably agree that the competent Courts of Oregon shall have jurisdiction to hear and determine any suit, action or proceeding, and to settle any dispute which may arise out of, under, or in connection with the Declaration and for such purposes hereby irrevocably submit to the jurisdiction if such Courts. Nothing contained herein shall limit the right of Rose City Dental Care to take proceedings in any other jurisdiction whether concurrently or not.

I ACKNOWLEDGE and ACCEPT that this Declaration will be considered as my consent to Rose City Dental to disclose, share, record and store this Declaration with any relevant authority or service provider for the purposes of ensuring the safety and security of any and all third parties that may come in contact with me prior, during, and after appointment.

If over the previous twenty one (21) days prior to the flight, I have visited any of the countries, states or regions that have a CDC Level 3 Health Notice or to travel t which is restricted to US President's proclamation, upon Rose City Dental operators request, I AGREE to provide a written verification executed by a licensed physician or medical facility prior to dental appointment confirming that (I) CDC-approved Coronavirus test was administered

on me and was negative or (ii) I do not meet the CDC criteria for administering Coronavirus test and do not exhibit any Coronavirus symptoms.

I AFFIRM that all the above statement applies equally to the following minors under the age of 18 (either with me or with my consent) at any Rose City Dental Care office and who are in my custody of care, if any (please attach an additional page as needed):

If any above statement is not wholly true, please provide a full explanation here:

In signing below, I. An individual over the age of 18 of sound mind, knowingly, voluntarily, and freely agree to the terms of this binding Declaration, and in doing so represent the truthfulness and veracity of the answers.

__________________________ __________________________

(signature) (date)