

# COVID-19 SELF-ASSESSMENT

**DO YOU HAVE COVID SYMPTOMS?**

- Fever or feeling feverish (chills, sweating)
- New Cough
- Difficult Breathing
- Sore Throat
- Muscle Aches or Body Aches
- Vomiting or Diarrhea
- New Loss of Taste or Smell

**YES** ←

→ **NO**

**HAVE YOU TRAVELED**

Outside of the United States or to any U.S. State subject to the NY State advisory within the last 14 days?

**YES** ←

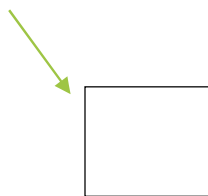
→ **NO**

**HAVE YOU TESTED POSITIVE, OR HAD CLOSE CONTACT?**

With anyone who has tested positive, for COVID in the last 14 days?

**YES** ←

→ **NO**



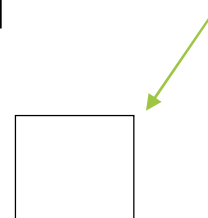
IF ANY 'YES', CHECK HERE.

**YOU ARE IN A COVID RISK CATEGORY**

Please CANCEL your appointment,

If you appear and have answered yes to any of these questions, Access will be DENIED.

Please contact the court immediately to reschedule.



IF ALL 'NO', CHECK HERE.

**YOUR ASSESSMENT IS SATISFACTORY**

Remember to wear your mask