

**SRI LANKA MEDICAL COUNCIL
 COVID 19 RISK FACTOR DECLARATION
 EXAMINATION FOR REGISTRATION TO PRACTICE MEDICINE (ERPM PART A AND PART D)**

Name :		Index No :
Age:	NIC No :	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address :		
Contact No :		

PRESENTING RISK FACTORS :

Symptoms	Yes	No
Fever (Temp - F)		
Cough		
Sore Throat		
Difficulty in breathing		
Myalgia		
Quarantined Dates :		
PCR Tests Dates : 01. 02.		
Do you have anyone at home with the above symptoms?		
Is anyone in your family in quarantine?		
Overseas travel - Date returned to Sri Lanka :		
Are you from any identified COVID 19 lockdown areas?		
Have you been in contact with suspected or confirmed COVID 19 patient		

Date :

Time :

I hereby declare that the foregoing is true and correct

Signature :