Atlantic County
Meadowview Nursing and Rehabilitation Center

VISITATION ATTESTATION FORM

By completing and signing this attestation form, you confirm that you have read and reviewed the procedures provided which are required for visitation with residents of this facility.

Your Name: _____

Name of resident you are visiting: _____

Today's Date: _____

Contact Phone Number: _____

I certify that I do not have any of the following symptoms:

- Fever
- Cough
- Shortness of Breath
- Congestion or Runny Nose
- Sore Throat
- Muscle or Body Aches/Pain
- Chills
- Fatigue
- New Loss of Taste or Smell
- Diarrhea
- Nausea or Vomiting

I also certify:

- I have not been in close contact **within the last 14 days** with anyone who is ill with respiratory illness.
- I have not been in close contact **within the last 14 days** with anyone with a confirmed diagnosis of Corona Virus disease 2019 (COVID-19) or who is under investigation for COVID-19.

I understand:

- I will have to follow proper handwashing procedures
- **All VISITORS Must Sign the LOG.**
- I will practice social distancing, have no physical contact and remain six feet apart in common areas.
- The possible dangers of exposure to COVID-19 and agree to follow the rules of the facility.
- I will notify the facility if I test positive for COVID-19 or exhibit symptoms of COVID-19 within 14 days of today's visit.
- I will adhere to Core Principles of COVID-19 Infection Prevention.

_____ Date: _____

(Visitor's Signature)