

**Financial Services
Tribunal**

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Attendance Day Screening/Re-Screening Questionnaire

1. Are you currently experiencing one or more of the symptoms below that are new or worsening? These questions are not related to chronic conditions or symptoms related to other known causes or conditions.

Do you have <u>one or more</u> of the following symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fever and/or chills	Temperature of 37.8°C / 100°F or higher <input type="checkbox"/> Yes <input type="checkbox"/> No
Cough or barking cough (croup)	Not related to asthma, post-infectious reactive airways, COPD, or other know causes or conditions you already have <input type="checkbox"/> Yes <input type="checkbox"/> No
Shortness of breath	Not related to asthma or other known causes or conditions you already have <input type="checkbox"/> Yes <input type="checkbox"/> No
Decrease or loss of smell or taste	Not related to seasonal allergies, neurological disorders, or other known causes or conditions you already have <input type="checkbox"/> Yes <input type="checkbox"/> No
(For adults age 18 years or over) Fatigue, lethargy, malaise and/or myalgia	If you <u>have not</u> received a COVID-19 vaccination in the last 72 hours and are experiencing unusual tiredness, lack of energy (not related to depression, insomnia, thyroid dysfunction, to other know causes or conditions you already have) muscle pains, aches, and pain associated with ligaments, tendons, and the soft tissues that connect bones, organs, and muscles your answer for this item should be "Yes" If you <u>have</u> received a COVID-19 vaccination in the last 72 hours and are experiencing mild fatigue that only began after vaccination, but not the unusual symptoms referred to in the questions above, your answer for this item should be "No". <input type="checkbox"/> Yes <input type="checkbox"/> No
(For children under age 18 years) Nausea, vomiting and/or diarrhea	Not related to irritable bowel syndrome, anxiety, menstrual cramps, or other known causes or conditions you already have <input type="checkbox"/> Yes <input type="checkbox"/> No

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2. In the last 14 days, have you travelled outside of Canada AND been advised to quarantine (as per the federal quarantine requirements)?

Yes No

3. Has a doctor, health care provider, or public health unit told you that you should currently be isolating (staying at home)? This can be because of an outbreak or contact tracing.

Yes No

4. In the last 10 days, have you been in in close contact with someone who currently has COVID-19?

If public health has advised you that you do not need to self-isolate (e.g., you are “fully immunized”¹ or have tested positive for COVID-19 in the last 90 days and since been cleared), select “No.”

Yes No

If you have already gone for a test in response to the Alert and got a negative result, select "No."

If you are fully immunized or have tested positive for COVID-19 in the last 90 days and since been cleared, select "No."

Yes No

5. In the last 10 days, have you tested positive on a rapid antigen test or a home- based self-testing kit?

If you have since tested negative on a lab-based PCR test, select “No.”

Yes No

6. In the last 14 days, has someone in your household (someone you live with) travelled outside of Canada AND been advised to quarantine (as per the federal quarantine requirements)?

If you are fully immunized or have tested positive for COVID-19 in the last 90 days and since been cleared, select “No.”

Yes No

¹ A fully immunized individual is defined as any individual more than 14 days after receiving their second dose of a two-dose COVID-19 vaccine series or their first dose of a one-dose COVID-19 vaccine series (e.g., Johnson and Johnson).

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7. In the last 10 days, has someone you live with been identified as a “close contact” of someone who currently has COVID-19 AND advised by a doctor, healthcare provider or public health unit to self-isolate?

If you are fully immunized or have tested positive for COVID-19 in the last 90 days and since been cleared, select “No.”

Yes No

8. Is anyone you live with currently experiencing any new COVID-19 symptoms and/or waiting for test results after experiencing symptoms?

If the individual experiencing symptoms received a COVID-19 vaccination in the last 48 hours and is experiencing mild fatigue, muscle aches, and/or joint pain that only began after vaccination, select “No.”

If you are fully immunized or have tested positive for COVID-19 in the last 90 days and since been cleared, select “No.”

Yes No

9. Are you fully immunized?

If you are fully immunized, select “Yes”. If not, select “No”. If you are unwilling to respond select “Unwilling to Respond”.

Yes No Unwilling to Respond

NOTE: Completion of this Questionnaire is required by the Survey you previously filed with the Registrar.

I HEREBY CONFIRM MY UNDERSTANDING OF THE REQUIREMENTS AND INFORMATION CONTAINED IN THE SURVEY AND FURTHER CONFIRM THAT THE ABOVE ANSWERS IN THIS QUESTIONNAIRE ARE TRUE AND CORRECT AS AT THE DATE WRITTEN BELOW.

Date - _____

Name of Participant (print) - _____

Signature of Participant - _____

Participant’s Phone Number - _____