DECLARATION FOR DOCTORS

I, ____, am fully aware of RA 11332 Mandatory Reporting of Notifiable Disease and Health Events of Public Health Concern Act.

I declare that:

I am fully aware of CMCI COVID-19 Protocols.

I acknowledge my responsibility and commitment to abide by these CMC protocols which are keys to the success of Capitol Medical Center Inc.'s efforts to help prevent the spread of COVID-19 infection.

I acknowledge the importance of monitoring my own health and my responsibility to notify the Infection Control Nurse and my close contacts within CMC if I become symptomatic and/or exposed, and need to be tested, if necessary.

I accept that this declaration shall be renewed on a monthly basis in order for me to obtain my pass to CMCI premises.

________________________________	________________________
Signature over Printed Name	Date