|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Household of Shielder Notification Form** | | | | | |  |  |  |  |
| Your Name: | |  |  | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |
| Your Date of Birth: | |  |  | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |
| Are you part of a household where, | | | |  |  |  |  |  |  |
| someone who was asked to shield? | | | |  |  |  | Yes | No |  |
|  |  |  |  |  |  |  |  |  |  |
| Is the person, who shielded, that you live with | | | | |  |  |  |  |  |
| a patient at our practice? | | |  |  |  |  | Yes | No |  |
| If you answered No, which | | |  |  |  |  |  |  |  |
| practice do they belong to: | | |  | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |
| Shielding Person's: | |  |  |  |  |  |  |  |  |
| Name |  |  |  | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |
| Relation to you | |  |  | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |
| Signature: | |  |  | | | | | |  |
|  |  |  |  |  |  |  |  |  |  |