|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **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: |  |    |   |
|   |   |   |   |   |   |   |   |   |   |