**COVID-19 Case Report Form**

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| --- | --- |
| Affiliation |  |
| Job title or academic year |  |
| Name |  |
| Contact | Tel.: － －  (Self / Family member / Other [pls. specify:　　　　　])  E-mail: |
|  | |
| 1. Date of reporting | / / (MM/DD/YYYY) |
| 1. Date of diagnosis | / / (MM/DD/YYYY) |
| 1. Medical institution |  |
| 1. Current state | □ Self-quarantine (Address:　　　　　　　　　　　　　　　)  □ Hospitalized (or awaiting hospitalization)  　Medical institution: |
| 1. Date of symptom onset (e.g., fever, cough, other respiratory symptoms) | / / (MM/DD/YYYY) |
| 1. History of domestic or overseas business/leisure trips in the month before diagnosis | □ No trips  □ Period(s): / / to / / (MM/DD/YYYY)  Destination(s): |
| 1. Activity and contact history for the two weeks before symptom onset | Attachment 1 |
| 1. Activity history since symptom onset | Attachment 2 |
| 1. Physician/government agency prognosis and other relevant information |  |

Tick one box.

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| I hereby   * agree　　　　　　　□ do not agree   to the disclosure of information on my condition to people with whom I have or may have been in close contact. |

Note: The details of this form are subject to circumstance-based changes.