ST. VINZENZ-KRANKENHAUS HANAU
gemeinnützige GmbH

VINZENZ GRUPPE FULDA

VISITOR FORM

PLEASE FILL OUT LEGIBLE IN BLOCK LETTERS AND SIGN!

PATIENT NAME: _____ STATION: _____

VISITOR DATA

Name / First name: _____

Street / House no.: _____

Place / Postal code: _____

Telefone number: _____

HEALTH ISSUES

Did you have a COVID-19 disease?

Yes ☐ No ☐

Do you have fever, cough, difficulty in breathing, no sens of smell or no tast of flavour, diarrhea or sore throat?

Yes ☐ No ☐

Did you visit a COVID-19-risk area according to the official list of the Robert-Koch-Institut within the last 14 days?

Yes ☐ Nein ☐

Are you recovered from a COVID-19 disease? (verification)

Yes ☐ No ☐

Complete immunized? (verificaton)

Yes ☐ No ☐

Covid-19 rapid test from an approved test center (not older than 24 hours)?

Yes ☐ No ☐

Please have your passport ready!

Date/ signature visitor

verification prooved, signature employee

1. With signing this declaration, I confirm the accuracy and completeness of my answers to the questions above.
2. Every visitor of our hospital has the right to refuse the asked information's in this form, respectively the right to refuse to sign it. In this case, we need to deny your visit in the hospital.
3. I confirm, I took note of the hygiene guidelines of the hospital and I will follow them.
4. I hereby consent to the processing of my data for the purposes indicated of my visit in the hospital in accordance with Art. 9Abs. 2 lit. i Datenschutzgrundverordnung.
5. Please understand that we will have to ask you the questions above at every visit.

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