Clear Form

Josephine County Public Health

Patient First Name:_____________ Patient Last Name:_______________ Phone: ______________
DOB:(MM/DD/YYYY) _________ Address: ______________________________ City: _______________
Reporting Health Dept:_________________________________ Email:__________________________

Interviewer Information:

Name of Interviewer: Last:_______________________________ First:_______________________________
Email:____________________________________ Phone: ___________________

Contact Information

Date: _____________________

Contact First Name ___________________________ Exposure: Travel ________________
Contact Last Name ___________________________ Underlying Conditions?
Contact DOB (MM/DD/YYYY) __________________ ☐ Yes ☐ No
Contact Phone _______________________________ Date of Last Exposure: ________________
Contact Email ________________________________

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