COVID-19 SCREENING SELF-DISCLOSURE FORM

Like all organizations, we continue to respond to the evolving COVID-19 crisis. Maintaining the safety and well-being of our employees and contractors remains our top priority. The COVID-19 outbreak requires precautions to be taken for early and effective detection of suspected cases to limit the exposure to others. As a result, we are requesting you complete the following form prior to returning to work or prior to providing services at a CNOOC worksite. Completed forms should be provided to CNOOC medical personnel at the following confidential email address COVID19@intl.cnoocltd.com.

The information in this form will be collected, used and disclosed as described below. The completed form will be maintained as a confidential medical record in accordance with applicable law. A CNOOC Health Care Professional will review your answers and discuss next steps with you if required. Management will be advised only of work restrictions and related information necessary to protect your health and safety and the health and safety of others. Information will be released only with your consent or as otherwise permitted by applicable law.

NOTICE: INDIVIDUALS ACCESSING A CNOOC INTERNATIONAL SITE MAY BE SUBJECT TO A TEMPERATURE SCREENING PRIOR TO EACH SITE ENTRY

CONFIDENTIAL

(PRINT – USE black Ink or complete electronically) **Identification**				
Last Name	**First Name**	**Middle Name**	**Employee ID**	**Contractor?** ☐ **Yes** ☐ **No**
Facility	**Location** ***(City, Province)***		**Contracting Company**	
Work Telephone ***(Include Area Code)***	**Cell Phone** ***(Include Area Code)***	**CNOOC Supervisor Name**		
Date Last Worked / Last Day Services Provided		**Date of Next Scheduled Shift / Return to Providing Services**		

History			
Please respond to the following:	**Check response** **Yes**	**No**	**If yes, explain:** (use back if more space needed)
1. In the past 14 days have you travelled internationally?	☐	☐	
a. If Yes – Are you in compliance with our LLK Site Access Requirements related to international travel? (see below)	☐	☐	
If you travel outside of Canada and you are fully vaccinated with a Health Canada approved COVID-19 vaccine you are able to return to the Long Lake Site immediately. You will be required to participate in daily Antigen Testing for your first 5 days back on site and then transition over to your regular Rotary Testing Schedule. If you are not fully vaccinated, you will not be permitted entry to the Long Lake Site until you have been back in Canada for a minimum of 14 days.			
2. In the past 14 days have you:	**Yes**	**No**	**If yes, explain:** (use back if more space needed)
a) Been advised to self-isolate or quarantine by a doctor, health authority or another worksite clinician?	☐	☐	
b) Lived in the same household as a confirmed positive COVID-19 case?	☐	☐	
c) Had close contact with a confirmed positive COVID-19 case (e.g., physical contact; shaking hands; sharing food/drink; sharing vehicle, etc.)?	☐	☐	
d) Been tested for COVID-19?	☐	☐	

3. Do you have any of the following symptoms? Check all that apply in *both* columns (items a – m). If yes to any, use back to explain.

	Yes	**No**		**Yes**	**No**
a) Sore throat	☐	☐	h) Muscle or joint aches	☐	☐
b) Painful swallowing	☐	☐	i) Headaches	☐	☐
c) Cough (new or worsening chronic cough)	☐	☐	(j) Severe exhaustion/fatigue	☐	☐
d) Fever/chills	☐	☐	k) Loss of sense of smell and/or taste	☐	☐
e) Runny/stuffy nose	☐	☐	l) Gastroenteritis (nausea, vomiting, diarrhea, unexplained loss of appetite)	☐	☐
f) Difficulty breathing	☐	☐	m) Conjunctivitis (pink eye)	☐	☐
g) Shortness of breath	☐	☐			

I hereby declare that the answers to all questions are, to the best of my knowledge, correct, and that I have not withheld any information regarding my present health.

I understand that my entry to any CNOOC site may be denied if, among other things: (i) I am exhibiting symptoms of COVID-19 or have been diagnosed as having COVID-19; (ii) the temperature screening results in a level at or above a level that concerns a medical expert; or (iii) a "Yes" response is recorded to any of the questions in the History section above.

I understand that failure to provide truthful and accurate responses to the questions on this form may result in corrective action.

I understand that my personal information will be dealt with in accordance with any applicable privacy laws and regulations and applicable policies.

Signature of Worker Completing History Form_____Date _____

Signature of Examining Licensed Health Care Professional_____Date _____