Inner City Cycling Connection
A 501(C3) Non-Profit Organization
P.O. Box 82311
Los Angeles, CA 90082

NURSE OR DOCTOR USE ONLY

Review By______________________________________

Body Temp______________________________________

Blood Pressure___________________________________

Other Information__________________________________

Office: (323)839-5012 Fax: (323)291-2582 Email: ic3cycling@gmail.com
www.innercitycycling.org

COVID-19 TESTING PATIENT PERSONAL INFORMATION AND QUESTIONAIRE

TEST DATE: ____

APPLICANT INFORMATION (Please Print Clearly)

Applicant Name	Mr./Ms./Mrs.	First Name	M.I.	Last Name
Mailing Address	Address	Street		Apt. #
	City		State	Zip Code
Contact Information	( ) Day Time Phone No.	( ) Evening Phone No.		( ) Cell Phone No.
	Fax No.: ( ) --			
	Email Address:			
	Birthday:			
Are You A Cyclist?	Yes [ ] No [ ]	Occupation		

QUESTIONAIRE

(Please take a moment and answer the questions below so that we can continuously improve on our quality of service)

How did you hear about this event?	
Did you have a recent hospital or doctor visit? If yes, please give the visit date and the reason for the hospital or doctor visit.	
Do you have any pre existing medical conditions? If yes, please describe.	
Are you on medication? If yes, please describe.	
Additional comment(s)	

I HAVE READ AND UNDERSTAND THE INFORMATION ON THIS FORM FULLY AND HAVE FILL IT OUT AS ACCURATELY AS POSSIBLE.

Signature of Applicant____**DATE**____________________