COVID-19 Test Record

_______________________________ had a COVID-19 test performed by (name of medical practice).
(Print Patient Name)

Specific information about the test is documented below.

Date of test: ______________________

Result of test:  □Negative  □Positive

Type of test:  □Antigen  □Molecular (NAA)  □Other ________________________________

If needed, specific test performed: ________________________________________________

__________________________________________  ______________________
(Printed Name of Test Administrator)  (Signature of Test Administrator)

________________________
(Date signed)