MIDWEST RESEARCH GROUP
ST. CHARLES PSYCHIATRIC ASSOCIATES
4801 WELDON SPRING PARKWAY • SUITE 300
ST. CHARLES, MO 63304

In conjunction with the St. Louis City Health Department's Order dated May 11, 2020, I certify the following to be true:

1. I am not currently experiencing a fever over 100.4 and have not experienced a fever of 100.4 for the last 72 hours.

2. I am not experiencing illness, including but not limited to new shortness of breath, new or worsened cough, sore throat, or a loss of taste or smell.

3. I have not been exposed to any person(s) with a confirmed case of COVID-19 for the last 14 days.

4. I have not traveled out of the country or been exposed to any area with a high number of confirmed cases of COVID-19 for the last 14 days.

5. I will not come into the office if I feel ill or come into contact with someone who has a confirmed case of COVID-19.

6. I agree to wear a mask while in the office.

7. I will contact the office if the information in this certification changes.

If your answers to all the above questions are YES, please sign and date this form and email to **frontdesk@STCPsych.com**. This electronic signature is considered as an original.

If your answers to any one of the above questions is NO, do **not** come into the office and contact the office at 636-949-5760 to make other arrangements.

Thank you for your cooperation and patience.

Patient Name	Date of Birth
Signature	Date