ALBEMARLE®

VISITOR HEALTH SCREENING FORM

Dear Guest,

Out of care for our team, guests and community, we are temporarily requiring that site visitors complete a COVID-19 screening questionnaire. This is part of our effort to prevent the spread of the virus and to reduce the risk of exposure for our team and partners, including yourself.

Entrance to the site is contingent on your completion of this form, as well as approval by a designated Albemarle team member who will review the document. This form will be considered confidential and will be destroyed 30 days after the signing date. We appreciate your patience and participation as we keep safety top of mind.

<table>
<tr><td colspan="3">Visitor's Full Name:
氏名</td><td colspan="2">Phone Number:
電話番号</td></tr>
<tr><td colspan="5">Please list all countries and states you or an immediate family member have travelled to/from in the past 14 days: お客様と近親者方の過去14日間の渡航先全てをご記入ください</td></tr>
<tr><td colspan="5">Visitor's Organization/Company (if applicable):
御社名</td></tr>
<tr><td colspan="3">Name of Albemarle Host: 弊社記入欄/担当者</td><td colspan="2">Recorded by Staff (Name): 弊社記入欄/記録者</td></tr>
<tr><td></td><td colspan="4">Self-Declaration By Visitor</td></tr>
<tr><td>1</td><td>☐ No symptoms
右の項目に該当しません</td><td>If you have the following symptom(s), please tick the relevant box(es):
右に該当がある場合は×をご記入下さい。</td><td>☐ Fever 発熱
☐ Sore throat 喉の痛み
☐ Dry cough 咳
☐ Runny nose 鼻水
☐ Body aches 関節痛</td><td>☐ Abnormal Headaches 頭痛
☐ Shortness of breath 呼吸困難</td></tr>
<tr><td>2</td><td colspan="4">To your knowledge, have you been in contact with a confirmed COVID-19 patient in the past 14 days? 過去14日間に新型コロナウイルス肺炎の感染者と接触がありましたか
☐ Yes ☐ No</td></tr>
</table>

Signature (Visitor): お客様署名_____ Date: _____

Signature (Reviewer): 確認者署名_____ Date: _____

Additional Comments:

_____

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