**COVID-19 SCREEN[[1]](#footnote-1)**

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING:**

1. In the past 14 days, I have ***not***experienced any of the following symptoms: Fever/cough/shortness of breath/smell or taste loss

TRUE\_\_\_\_\_ Skip to Question 3 FALSE \_\_\_\_\_ Continue to Question 2

1. Chief complaints: Fever\_\_\_\_ Cough \_\_\_\_ Shortness of breath\_\_\_\_ Others\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximate date of symptoms onset: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you traveled domestically (to another state other than for work) or internationally within the last 14 days? Yes\_\_\_ No\_\_\_ If yes: Where \_\_\_\_\_\_\_\_\_\_\_\_\_ When\_\_\_\_\_\_\_\_\_\_\_\_ Date returned home: \_\_\_\_\_\_\_\_\_\_\_\_
2. Has anyone you have had close contact2 with traveled domestically (to another state other than for work) or internationally within the last 14 days? Yes \_\_\_ No \_\_\_ If yes: Where \_\_\_\_\_\_\_\_\_\_\_\_\_ When \_\_\_\_\_\_\_ Date returned home: \_\_\_\_\_\_\_\_\_
3. When did you last work on company premises? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Have you been tested for COVID19? Yes\_\_\_ No\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Has anyone you have had close contact2 with been confirmed with COVID19 or awaiting test results?

Yes\_\_\_ No\_\_\_\_ If yes: Date confirmed \_\_\_\_\_\_\_\_\_\_\_\_\_ (OR) Date tested \_\_\_\_\_\_\_\_\_\_\_\_

1. Has anyone you have had close contact2 with had a fever, cough, shortness of breath or smell or taste loss within the last 14 days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes: When was your last contact with them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you been tested for Influenza within the last 14 days? Yes \_\_\_\_\_\_ No \_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_ Results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Has anyone you have had close contact2 with been confirmed with Influenza or awaiting test results in the last 14 days? Yes\_\_\_ No\_\_\_\_ If yes: Date confirmed \_\_\_\_\_\_\_\_\_\_\_\_\_ (OR) Date tested \_\_\_\_\_\_\_\_\_\_\_\_
3. Is anyone you have had close contact2 with working in the health care industry, or in any position that exposes them to the public (e.g. working in a grocery store, law enforcement)?

Yes\_\_\_ No\_\_\_\_ If yes: Describe the position \_\_\_\_\_\_\_\_\_\_\_\_\_ When did they last work? \_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature: Date:

1. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

2”Close contact” is defined as anyone who has been within 6 feet of a person infected with the virus for a prolonged period of time

Legal Disclaimer: If you believe you need a reasonable accommodation, please contact your HR Business Partner. We will comply with the legal obligation to engage in an interactive process to make an individualized determination as to whether or not a reasonable accommodation can be provided. [↑](#footnote-ref-1)