

Employee Screening Tool

Please let us know if you **or anyone in your household** have any of the following (check all that apply):

	Yes	No
Fever greater than or equal to 100.0° F (37.8° C), <u>OR</u> any of the following symptoms: <ul style="list-style-type: none"> • Feel Ill • Chills or muscle aches • Shortness of breath • Sore throat • New or changed cough (not otherwise associated with a known chronic condition like smoking or allergies) • Head ache • New loss of taste or smell 		
Traveled internationally or on a cruise ship within the last 14 days?		
Had close contact * with someone who has confirmed or presumed COVID-19 (Coronavirus) within the last 14 days?		
Today's Temperature: _____ (if unknown or not taken, temperature must be taken and documented here prior to admission)		

****Close contact is defined as someone who was within 6 feet or less of an infected person for a cumulative total of 15 minutes or more over a 24-hour period* starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the person is isolated.***

What was your temperature today? _____

If you have any of the above symptoms or exposures, **contact your supervisor or HR representative immediately and prior to going to work.**

Thank you for your understanding and cooperation in helping us keep everyone safe.

I certify that this information is accurate to the best of my knowledge and that I will report any changes in these conditions immediately.

Name: _____

Date: _____

Signature: _____