COVID-19 Employee Screening Form

Employee Name: _____ Company Name: _____

Date of Screening: _____ Temperature: _____

Employee Email: _____ Employee Phone #: _____

SCREENING QUESTIONS:

Have you recently started experiencing any of the following symptoms?

- ☐ Fever or chills
- ☐ Mild or moderate difficulty breathing
- ☐ New or worsening cough
- ☐ Sustained loss of smell, taste, or appetite
- ☐ Congestion or runny nose
- ☐ Sore throat
- ☐ Nausea or Vomiting
- ☐ Diarrhea
- ☐ Aching throughout the body
- ☐ None of the above

In the last fourteen (14) days, have you traveled internationally or visited an area where COVID-19 is widespread?

- ☐ Yes, I have traveled internationally
- ☐ Yes, I have visited an area where COVID-19 is widespread
- ☐ None of the above
- ☐ I don't know

In the last fourteen (14) days, what has been your exposure to others who are known to have COVID-19?

- ☐ I live with someone who has COVID-19
- ☐ I have had close contact with someone who has COVID-19 (I was within 6 feet of someone who is sick and did not wear a protective mask, or I was exposed to a cough or sneeze)
- ☐ I've been near someone who has COVID-19 (I was at least 6 feet away or I wore a protective mask and was not exposed to a cough or sneeze)
- ☐ I have had no exposure (I have not been in contact with someone who has COVID-19)
- ☐ I don't know

My signature below certifies that all information recorded above for the purpose of preventing the spread of COVID-19 in the workplace are true and accurate to the best of my knowledge.

_____ _____

Employee Signature Date

**Internal Use Only*

_____ _____

Provider Name Provider Signature