Employee Screening Tool

Please let us know if you have any of the following (check the appropriate box):

	Yes	No
Fever greater than or equal to 100.0° F (37.8° C), **and** one or more of the following: muscle aches, shortness of breath, sore throat, new or changed cough, chills, headache, loss of taste or smell (new onset in the past 14 days)?		
Have you traveled internationally or on a cruise ship within the last 14 days?		
Have you or anyone in your household had close (within 6 feet) contact with someone who is under investigation for or has laboratory-confirmed COVID-19 within the last 14 days?		

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_____

This information is subject to HIPAA protections and will be stored in a separate locked location.

Updated 5-1-20