Name: _____

Date: _____

Job Title: _____

Work Site: _____

Name of person administering the test: _____

Yes	NO	
☐	☐	Do you have a fever?
☐	☐	Cough?
☐	☐	Headache?
☐	☐	Sore throat?
☐	☐	Runny nose or congestion?
☐	☐	Is anyone in your household experiencing those symptoms?
		Record the temperature of the employee. _____

(The questionnaire should be kept confidential, except under the request of a Public Health Official)

If the answer to any of the above is YES:

1. Employee is requested to report home
2. If employee can perform their duties remotely, then they work remotely
3. Employee is directed to contact their personal Health Care Provider for assessment.

Return to work after symptoms:

- The employee certifies in writing that the employee is fever-free and has been completely symptom free (no coughs, no chills, no symptoms consistent with COVID-19) for at least three (3) days; AND
- At least seven (7) days have passed since the later of the onset of symptoms that led to the employee being sent home or a positive COVID-19 test.

OR

- The employee provides documentation from a medical provider confirming that the employee can return to work, that the employee had a negative test for COVID-19 (if testing is available), and that any lingering symptoms, if applicable, are not the result of a contagious illness.