Coronavirus (COVID-19) Screening Questionnaire

The purpose of this Coronavirus (COVID-19) Screening Questionnaire is to help make decisions about entering our workplace and/or seeking appropriate medical care. This questionnaire is not intended for the diagnosis or treatment of disease or other conditions, including the Coronavirus.

First Name: _____ **Last Name:** _____

Home City & State: _____ **Employee ID:** _____

Department: _____ **Manager:** _____

1. Indicate if you have had any of the following symptoms and the last time you experienced the symptom:

Symptom	3 days or less	3-7 days	1-2 weeks	2-4 weeks	1-3 months
Fever or feeling feverish (chills or sweats)					
Persistent Cough					
Shortness of Breath					

□ I have not and am not experiencing any of the above symptoms

2. Have you had personal contact (live with, provide care for) anyone who is known to have or suspected to have COVID-19 (Coronavirus)? □ YES □ NO

3. In the past 14 days, have you traveled internationally? □ YES □ NO

4. In the past 14 days, have you traveled with large groups of people in confined spaces (e.g. airplanes, cruise ships, stagecoach buses)? □ YES □ NO

By signing, I verify that the information supplied is true and complete. I also understand that any person who knowingly submits false information or misleading information, may be subject to penalties. By signing this form, I authorize the release of the information requested below, to CLIENT.

Signature: _____ **Date:** _____

Remember to use these precautions to avoid becoming ill

 **Wash Your Hands**	 **Avoid Close Contact Stay Home, if possible**	 **Cover Your Mouth & Nose When Near Others**	 **Cover Your Cough & Sneezes**	 **Clean & Disinfect Surfaces Regularly**

Visit https://www.cdc.gov/coronavirus for more information.