

EMPLOYEE COVID-19 SELF- SCREENING ASSESSMENT

The safety of our employees and students is our overriding priority. As the coronavirus (COVID-19) pandemic continues, we are monitoring the situation closely and following the guidance from the Centers for Disease Control and Prevention and local health authorities. In order to prevent the spread of the coronavirus and reduce the potential risk of exposure to our workforce, we are requiring everyone to ask themselves these questions daily prior to arriving at the workplace. Please **do not enter** the workplace if you answer “Yes” to any question 1-6; contact your supervisor, follow [CDC guidelines](#) and submit the appropriate [Online Reporting Form](#) immediately. **Please respond to each of the following questions, truthfully, commonsensically and to the best of your ability.** Your participation is important to help us take precautionary measures to protect you and the other employees and students.

Representations	
1	<p>Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? (<i>Please take your temperature before you answer this question.</i>)</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Fever (100.4° F/37.8° C measured by a thermometer)</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Cough</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Shortness of breath or difficulty breathing</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Sore throat</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> New loss of taste or smell</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Chills</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Head or muscle aches</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Nausea, diarrhea, vomiting, new GI symptoms</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/> Runny nose, or new sinus congestion</p>
2	<p>In the past 14 days, have you been in close proximity to anyone who was experiencing any of the above symptoms or has experienced any of the above symptoms since your contact?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
3	<p>In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
4	<p>Have you been tested for COVID-19 and are waiting to receive test results?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
5	<p>Have you tested positive for COVID-19, or are you presumptively positive for COVID-19 based on your health care provider’s assessment or your symptoms?</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
6	<p>Is there any reason why you feel you are at higher risk of contracting COVID-19? If yes, contact your supervisor for possible work solutions.</p> <p>65 or older <input type="checkbox"/> Diabetes <input type="checkbox"/></p> <p>Chronic Lung Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/></p> <p>Serious Heart Condition <input type="checkbox"/> Kidney Disease (Dialysis) <input type="checkbox"/></p> <p>Severe Obesity <input type="checkbox"/> Autoimmune Disease <input type="checkbox"/></p>