Workplace Infectious Disease
Employee & Visitor Self-Certification Form

All employees/visitors are required to complete this form daily before entering this site.

<table>
<thead>
<tr>
<th>Employee Name:</th>
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<tbody>
<tr>
<td>Today’s Date:</td>
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Since your last day of work or visit to this site:

- Have you been in close contact with a confirmed case of COVID-19 within past 14 days?  
- Have you traveled internationally in the past 14 days?  
- Are you experiencing a cough, shortness of breath or sore throat?  
- Have you had any symptoms of a fever in the past 48 hours: chills, sweats, felt "feverish" or had a temperature of 100.4°F or greater?  
- Have you had new loss of taste or smell?  
- Have you had vomiting or diarrhea in the last 24 hours?  

[ ] YES  [ ] NO

If the answer the is ‘YES’, please contact the appropriate resource per our Workplace Infectious Disease Procedure:

To the best of my knowledge the above details are a true and accurate statement.

_________________________  ______________________
Signature                  Date