Workplace Infectious Disease

Employee & Visitor Self-Certification Form

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

Employee Name:	
Today's Date:	

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 100.4F 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**