COVID-19 DAILY SELF-ASSESSMENT

NAME: ________________________ **DATE:** __________

SIGNATURE: ________________________

All employees of (COMPANY) and their subcontractors are being asked to cooperate in mitigating and reducing the spread of COVID-19. Completing this questionnaire is one step in our efforts to assess current risk and respond appropriately. It is imperative that employees do not report to work while experiencing the below listed symptoms.

QUESTIONNAIRE

Question	YES	NO
Have you, a family member or someone in your household been in direct contact with someone who has been diagnosed or tested for COVID-19?		

If you answered yes, you are not allowed to continue working.

Question	YES	NO
Are you experiencing cold or flu like symptoms such as fever, cough or shortness of breath?		

If you answered yes, you are not allowed to continue working.

Question	YES	NO
Have you traveled outside the United States within the last 14 days?		

If you answered yes, you are not allowed to continue working.

Question	YES	NO
Have you traveled outside of the state in which you're currently working within the last 14 days?		

If you answered yes, which city and state? ________________________

According to current guidelines, if you answered "yes" to questions 1 and 2, **you must contact your primary care physician for direction on testing and quarantine.** If you answered yes to any of the above, please notify our company representatives immediately.

ADDITIONAL INSTRUCTIONS

Contact the following for further instruction and guidance:

(NAME OF HR), Human Resources, (PHONE NUMBER), (EMAIL ADDRESS)
(NAME OF SAFETY), Site Safety and Health, (PHONE NUMBER), (EMAIL ADDRESS)

For more information on how to protect yourself and if you feel you may be sick, click here.

For information on which locations within the United States that are considered at risk, click here.

Should you not have access to the internet, please ask for paper copy information packages.

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