RETURN TO WORK COVID-19 SCREENING QUESTIONNAIRE

The safety of our employees is our overriding priority. As the COVID-19 pandemic continues, we are monitoring the situation closely and following the guidance from the Centers for Disease Control and the NH Department of Health and Human Services. In order to prevent the spread of the coronavirus and reduce the potential risk of exposure to our workforce, we are asking everyone to complete and submit this questionnaire to your Manager, after returning from your vacation. <u>Please do not enter the worksite until your responses have been reviewed and your entry has been approved</u>. Please respond to each of the following questions truthfully and to the best of your ability. Your participation is important to help us take precautionary measures to protect you and our other employees.

Name: ________________________
Phone Number (mobile/home): ___________________
Position/Location: _____________________

Have you received COVID19 Vaccine: ☐ YES ☐ NO
Date of your last COVID19 vaccine dose: ____________

In the past 14 days, which State/s outside of the New England States (Maine, Massachusetts, Vermont, Rhode Island, or Connecticut) did you travel to? State/s____

1. Are you currently experiencing, or have you experienced in the past 14 days, any of the following symptoms? (Please take your temperature before you answer this question.)

   Yes ☐ No ☐ Fever (100.4° F/37.8° C or greater)
   Yes ☐ No ☐ Cough
   Yes ☐ No ☐ Shortness of breath or difficulty breathing
   Yes ☐ No ☐ Sore throat
   Yes ☐ No ☐ New loss of taste or smell
   Yes ☐ No ☐ Chills
   Yes ☐ No ☐ Head or muscle aches
   Yes ☐ No ☐ Nausea, diarrhea, vomiting

2. 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?

   Yes ☐ No ☐

3. In the past 14 days, have you been in close proximity to anyone who has tested positive for COVID-19?

   Yes ☐ No ☐

4. Have you been tested for COVID-19 and are waiting to receive test results?

   Yes ☐ No ☐

5. In the past 14 days, have you been tested positive for COVID-19, or are you presumptively positive for COVID-19 based on your health care provider's assessment or your symptoms?

   Yes ☐ No ☐

   ____

Certification I hereby certify that the responses provided above are true and accurate to the best of my knowledge.

Employee Signature: ___________________________ **Date:** __________________

Note: The information collected on this form will be used to determine only whether you may be infected with COVID-19 or at risk of spreading to others. The information on this form will be maintained as confidential. Any questions should be directed to your manager or to the director of clinical operations.

Access to worksite (circle one): Approved Denied

Signature: ___________________________ **Date:** ________________

Director of Clinical Operations