Name:

Title:

Date:

1. Do you have or have you had any of the following symptoms in the past 14 days?
   - ❑ Fever greater than 100 degrees Temperature now: _____
   - ❑ Difficulty breathing
   - ❑ Cough
   - ❑ Sore Throat

   If YES to any of the above, DO NOT ENTER.
2. Do you travel to or work at multiple facilities? ❑ Yes ❑ No (If no, proceed to #6)
3. If yes, list those facilities:
   a) _____
   b) _____
   c) _____
   d) _____
4. Has any facility visited been identified as having COVID-19 positive individuals?
   ❑ Yes ❑ No
5. Do you change clothing between locations. ❑ Yes ❑ No
6. Do you wear PPE during visits at ALL locations. ❑ Yes ❑ No
7. Have you been tested for COVID-19 ❑ Yes ❑ No Date/Results: _____
8. Have you traveled in the past 14 days? ❑ Yes ❑ No
9. Have you had contact with anyone confirmed to have COVID-19 in the past 14 days?
   ❑ Yes ❑ No
10. All individuals entering the facility must monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility. If symptoms occur, you must immediately notify the facility of the date you were here, the individuals you were in contact with, and the locations within the facility visited. Do you agree to comply with this order? ❑ Yes ❑ No

PLEASE DO NOT CONTINUE INTO THE FACILITY UNTIL THIS FORM HAS BEEN REVIEWED BY FACILITY STAFF

❑ Visitor ❑ Vendor ❑ Allied Health ❑ Physician

Company Name(if applicable):_____

Signature: _____ Date: _____

Printed Name: _____ Contact #_____

Staff Screener Initials _____

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