COVID-19 Self-Screening Questionnaire

To protect everyone, we are asking employees to complete the following questionnaire daily prior to coming to work.

Please answer the following questions by check marking "yes" or "no"	**Yes**	**No**
In the last 14 days have you had any known contact with someone confirmed with diagnosis of COVID-19, or under investigation of COVID-19?	☐	☐
Have you had a fever (100.4 or higher) or chills in the last 48 hours?	☐	☐
Do you have a new persistent cough?	☐	☐
Are you experiencing shortness of breath or difficulty of breathing?	☐	☐
Do you have a sore throat?	☐	☐
Do you have congestion or runny nose?	☐	☐
Do you have repeated shaking with chills?	☐	☐
Do you feel fatigued?	☐	☐
Are you nauseous or vomiting?	☐	☐
Do you have diarrhea?	☐	☐
Do you have muscle pain or body aches?	☐	☐
Do you have a headache?	☐	☐
Are you experiencing new loss of taste or smell?	☐	☐

If you answered “yes” to any of these questions, we ask that you reschedule your start date.

If you answered “No” to all of these questions, please continue to self-monitor daily for respiratory symptoms such as fever (100.4 or above), cough, shortness of breath, sore throat, runny or stuffy nose, body aches, fatigue, headache, muscle pain, chills, fatigue, nausea, vomiting, diarrhea or new loss of taste or smell] report any symptoms immediately and do not come to work.