# Employee Screening Form

**Employee name: _____**

**Job title:_____**

**Supervisor's name: _____**

**According to the Centers for Disease Control (CDC), there are certain recognizable symptoms of COVID-19. In order to provide you a safe and healthy workplace, we ask that you let us know immediately if you do have any of these symptoms. We further ask that you remain at home if you have any symptoms; we will reach out to you to discuss work options.**

We will treat any medical information you give us in this screening as a confidential medical record in compliance with the Americans with Disabilities Act (ADA). That means we will only share this information on a "need to know" basis with supervisors, managers, first aid and safety personnel, and government officials. (See 42 U.S.C. §§12112(d)(3)(B), (4)(C); 29 C.F.R. §1630.14(b)(1)).

## Please complete this screening form and submit it every day, even if you do not have any symptoms.

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| **Do you have any of these symptoms?** **(Source:** https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html,) | **Fever (at or above 100.4 Fahrenheit) or chills; Cough; Shortness of breath or difficulty breathing; Fatigue; Muscle or body aches; Headache; New loss of taste or smell; Sore throat; Congestion or runny nose; Nausea or vomiting; or Diarrhea.**<br><br>***Note:*** *This list does not include all possible symptoms. CDC will continue to update this list as we learn more about COVID-19.* |
| **I have reviewed the information above, and certify that I am symptom-free today, _____ (fill in today's date).**<br><br>**Employee Signature: _____** | |