**Appendix B:**

**Employee Screening Form for COVID-19**

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| Facility Name: | | | |
| Employee Name: Job Title: | | | |
| Location of Job: Date of Screen: | | | |
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| **Recent History** | | | |
| Have you or any person with whom you have close contact traveled outside of the U.S in the last 21 days? \_\_\_\_\_\_Yes \_\_\_\_\_\_No  If so, which country, including lay over? | | | |
| Have you traveled to China, Italy, Iran or South Korea (including lay over) within 14 days \_\_\_\_Yes \_\_\_\_No | | | |
| Have you been in any states other than Missouri in the last 21 days? \_\_\_\_\_ Yes \_\_\_\_\_ No  If so, which states? | | | |
| Have you had close contact with any individual with a laboratory confirmed COVID-19 or Patient Under Investigation (PUI) for COVID-19? \_\_\_\_\_\_ Yes \_\_\_\_\_\_No  ***Close contact*** *is defined as being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time (15 to 30 minutes). Close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case or having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on).* | | | |
|  | | | |
| **Symptom Assessment** | | | |
| Do you have any of the following symptoms? | | | |
|  | Yes | No | Describe |
| Fever |  |  |  |
| Dry cough |  |  |  |
| Shortness of breath |  |  |  |
| **If the employee has a history of travel or contact and any of the above symptoms, please contact the employee’s supervisor. The employee may be asked to return home and contact their health care provider for treatment recommendations.** | | | |
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| Name of person completing the assessment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |