COVID-19 Workplace Health Survey

1. NAME: _____
2. DATE: _____

3. Have you had any of the CDC-recognized COVID-19 symptoms since your last day at work or the last time you were here?

- Cough YES _____ NO _____
- Shortness of breath or difficulty breathing YES _____ NO _____
- Fever YES _____ NO _____
- Chills YES _____ NO _____
- Muscle pain YES _____ NO _____
- Sore Throat YES _____ NO _____
- New loss of taste or smell YES _____ NO _____

4. Is there anyone in your household who is showing COVID-19 symptoms or who has been diagnosed with COVID-19?
   YES _____ NO _____
5. Have you been in close contact with anyone exhibiting signs or symptoms of fever, persistent cough or shortness of breath consistent with COVID-19 who has not been tested or is still awaiting testing?
   YES _____ NO _____