

**[INSERT MEDICAL PRACTICE NAME/LOGO]**  
**COVID-19 FACILITY ENTRANCE SCREENING FORM FOR EMPLOYEES**

The safety of the Practice's employees, patients, and visitors remains its top priority. To reduce the risk of the spread of and exposure to COVID-19, the Practice requires all employees (including temporary and contract workers) seeking entry to the Practice's facility to complete this screening form. This form will be used solely for the purpose of evaluating the potential hazards presented to the workplace. For the privacy of Practice employees, and in compliance with the Americans with Disabilities Act, the Practice will keep this form confidential and the name of a Practice employee will not be disclosed to coworkers outside of Human Resources and your immediate supervisor/manager or to others, except if and limited to the extent that disclosure is permitted or required by law or the employee (or the employee's authorized representative in the event of incapacity) voluntarily authorizes disclosure in writing. By signing this form, a Practice employee acknowledges receipt of the Practice's COVID-19 Policies and Procedures in effect as of the date of this form.

If, before reporting for your next shift, you experience any symptoms (excluding symptoms due to other known medical reasons) such as fever (above 100.4 degrees), cough, shortness of breath or difficulty breathing, sore throat, chills, repeated shaking with chills, muscle pain, headache, new loss of taste or smell, flu-like symptoms, or diarrhea, first call your supervisor/manager and do not report for work unless instructed to do so. If you develop such symptoms while working at the Facility, you must notify your immediate supervisor, who will direct you to leave the Facility until you satisfy the return-to-work conditions set forth below.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Practice Facility: \_\_\_\_\_

1. Within the past 24 hours, have you experienced any symptoms (excluding symptoms due to other known medical reasons) such as fever (above 100.4 degrees) or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, sore throat, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, or diarrhea?

YES     NO

2. Have you had any close contact during the last 14 days with someone diagnosed with COVID-19?

YES     NO

I acknowledge that if I answer "YES" to any of the above questions and unless I furnish written laboratory test results which are negative for COVID-19, with the specimen taken on or after the date of the "YES" answer, or as otherwise specified by the Practice's policies and procedures, I will be excluded from the Facility, and that I will be required to fill out a COVID-19 Symptomatic Screening Form electronically or via a telephone conversation with a Human Resources representative or supervisor/manager:

- a. until at least 24 hours have passed since recovery with no fever (below 100.4 degrees without the use of fever-reducing medications) and improvement in symptoms, and at least 10 days have passed since symptoms first appeared; or
- b. (Non-health care providers only) until 14 days have passed since I have had close contact with someone diagnosed with COVID-19.

\_\_\_\_\_  
Employee Signature

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To be completed by Supervisor/Manager (Check One):

\_\_\_\_\_ The individual has answered "NO" to all of the above questions and (if touchless thermometer is available) has not demonstrated a fever (above 100.4 degrees).

\_\_\_\_\_ The individual has answered "YES" to one or more of the above questions, and/or has demonstrated a fever (above 100.4 degrees) and has been excluded from the Facility.

Supervisor/Manager Signature: \_\_\_\_\_

Date: \_\_\_\_\_