[INSERT MEDICAL PRACTICE NAME/LOGO]

COVID-19 FACILITY ENTRANCE SCREENING FORM

The safety of the Practice's employees and other individuals visiting the Practice's facilities remains its top priority. To reduce the risk of the spread of and exposure to COVID-19, the Practice requires all employees (including temporary workers and contractor workers) and vendors seeking entry to Practice facility, to complete this COVID-19 Facility Entrance 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 management and to an employee's immediate manager/supervisor, 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 Preparedness and Response Plan in effect as of the date of this form.

If, before reporting for your next shift, you experience any of the Principal Symptoms of COVID-19 as defined in Question 1, below, first call your manager/supervisor and do not report for work unless instructed to do so. If you develop such symptoms while working at a Practice facility, you must notify your Worksite Safety Coordinator, who will direct you to leave the Practice facility until you satisfy the return-to-work conditions set forth below, or are otherwise cleared to return to work by the Practice.

1. Within the past 24 hours, have you experienced any of the Principal Symptoms of COVID-19 (listed below), or do you satisfy any additional exclusion criteria adopted by the Practice?

   One or more of the following (excluding symptoms due to other known medical reason):
   - ❍ Fever (above 100.4 degrees);
   - ❍ Shortness of breath;
   - ❍ Uncontrolled cough; ***or***

   Two or more of the following (excluding symptoms due to other known medical reason):
   - ❍ Abdominal pain;
   - ❍ Diarrhea;
   - ❍ Loss of taste or smell;
   - ❍ Muscle aches;
   - ❍ Severe headache;
   - ❍ Sore throat;
   - ❍ Vomiting.

   ☐ **YES** ☐ **NO**

2. Have you had any close contact during the last 14 days with someone diagnosed with COVID-19 or who has the Principal Symptoms as described above?

   ☐ **YES** ☐ **NO**

I acknowledge that if I answer "YES" to any of the above questions, that I will be required to fill out a Symptomatic Employee Screening Form electronically or via a telephone conversation with the Worksite Safety Coordinator, and that I will be excluded from the Practice's facilities:

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 there is an improvement in respiratory symptoms, and at least ten days have passed since symptoms first appeared; or
b. until 14 days have passed since I have had close contact with someone diagnosed with or symptomatic of COVID-19.

_____ _____

Signature Date

_____

Printed Name

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.

Worksite Safety Coordinator Signature: _____ Date: _____