**VISITOR AND EMPLOYEE HEALTH SCREENING CHECKLIST**

|  |  |
| --- | --- |
| Project Reference #:  | Subcontractor -Employee |
|  Address | Address: |
| City, State Zip | City, State, Zip |
| DATE:  | Phone Number: | Email |

Have you had any of the following symptoms that you cannot attribute to another health condition(s)?

Please **circle** “Yes” or “No” to each question.

Do you have or have you in the past 14 day(s):

|  |  |
| --- | --- |
| Yes or No | Been diagnosed with COVID-19? |
| Yes or No | Been asked to self-quarantine? |
| Yes or No | Been around anyone with COVID-19 symptoms? |
| Yes or No | Travelled?If yes, where? \_\_\_\_\_\_\_\_\_\_ |
| Yes or No | Attended any large group gatherings? |
| Yes or No | Fever or feeling feverish?  |
| Yes or No | Chills?  |
| Yes or No | Cough?  |
| Yes or No | Shortness of breath?  |
| Yes or No | Sore throat?  |
| Yes or No | Muscle aches?  |
| Yes or No | Headache?  |
| Yes or No | Loss or change of smell or taste?  |

Please be advised, if “Yes” to any of the screening questions, work will stop on your project/home. If subcontractor, you will stop all work on project/home. If employee, they will be advised to go home, stay away from other people, and contact their health care provider.

*Craig Tice, President.*