EMPLOYEE RESPONSE TO COVID-19 INTERVIEW QUESTIONNAIRE

(PRESumptive OR positive TEST) – updated October 29, 2020

EMPLOYEE NAME: ______________________________ DATE: ________________

INSTRUCTIONS: The following questions should be asked of any Employee who has informed you that she or he has either tested positive for COVID-19 or has been told by a medical treater or provider they presumptively have COVID-19. This questionnaire is to be kept confidential and in Employee’s medical file with access by only select individuals designated by the Company.

1. What is the date that you first exhibited symptoms, if any, of COVID-19?
   a. Date: ______________________________

2. What were the symptoms?
   a. Fever: Yes □ No □
   b. Headache: Yes □ No □
   c. Chills: Yes □ No □
   d. Cough: Yes □ No □
   e. Sore throat: Yes □ No □
   f. Body or Muscle aches: Yes □ No □
   g. Loss of taste/smell: Yes □ No □
   h. Shortness of breath/difficulty breathing: Yes □ No □
   i. Nausea, vomiting or diarrhea: Yes □ No □
   j. Congestion or runny nose: Yes □ No □
   k. Other: ____________________________________________ (describe)

3. When were you diagnosed with COVID-19 or presumed to have COVID-19?
   a. Date: ____________________________________________
   b. Tested positive: Yes □ No □
   c. Presumed to be positive: Yes □ No □

4. Name of medical professional or health care provider giving you the result or telling you that you are presumed to be positive:


All Rights Reserved 2020 SmithAmundsen LLC. This document is merely a sample form for educational purposes only and should not be construed as legal advice. Consult with competent legal counsel before acting on the information contained in this sample as the law is constantly evolving. All materials should be deemed work product of the author; all rights reserved.
5. What are your current symptoms?
   a. Fever (100.4°F or higher): Yes □ No □
   b. Headache: Yes □ No □
   c. Chills: Yes □ No □
   d. Cough: Yes □ No □
   e. Sore throat that you cannot attribute to another health condition: Yes □ No □
   f. Muscle or body aches that you cannot attribute to another health condition, or that may have been caused by a specific activity (such as physical exercise): Yes □ No □
   g. Loss of taste/smell: Yes □ No □
   h. Shortness of breath/difficulty breathing: Yes □ No □
   i. Nausea, vomiting or diarrhea: Yes □ No □
   j. Congestion or runny nose: Yes □ No □
   k. Other: ___________________________________________________(describe)

6. Have you been told by a medical professional to self-quarantine? Yes □ No □
   a. If yes, for how long (in days)? ____________________________
   b. If yes, have you been self-quarantined? If yes, since what date?
      ______________________________________________________

7. In the previous 30 days, have you had close contact with an individual confirmed or presumed to have COVID-19 (i.e. spent a total of 15 minutes or more over the course of a 24-hour period within 6 feet of the individual, or being coughed or sneezed on, even if the 15 minutes were not consecutive)? Yes □ No □
   a. If yes, give the date of last contact: ________________________
   b. If yes, explain your relationship to individual(s) with COVID-19: ________________________________________________
   c. If yes, identify the location of last contact: ____________________________________________________________
   d. If yes, identify whether any such contact is or was in your household: __________________________________________

8. In the previous 30 days, have you traveled to, or stopped over in, a country for which the CDC has issued a travel health notice (including but not limited to China, Iran, or Europe)? Yes □ No □

a. If yes, give country name and dates of travel:
   ______________________________________________________________________

9. In the previous 30 days, have you traveled domestically or internationally by airplane, bus or train?
Yes □ No □

   a. Details: ________________________________________________________________
   b. Date(s) of Travel: ______________________________________________________
   c. Destination(s): _________________________________________________________
   d. Accommodation(s): ____________________________________________________

10. In the previous 30 days have you used mass transit or public transportation?
Yes □ No □

   a. Details: ________________________________________________________________
   b. Date(s) of Travel: ______________________________________________________

11. Outside of work, have you attended any event or visited any public place in the previous 30 days where more than 10 individuals were in attendance and you were within 6 feet from any one individual for a total of 15 minutes or more, even if those 15 minutes were not consecutive? Yes □ No □

   a. Location: ______________________________________________________________
   b. Date(s): __________________________________________________________________

I certify that the above information was provided to me by telephone discussion with the above-named individual on the ____ day of ________________, 20___, and is accurately recorded herein.

By: __________________________________________

Print Full Name

Signature: ________________________________

Title: ________________________________
Confidential Checklist for Employer:

1. Did you receive any paperwork from Employee regarding their diagnosis of COVID-19?  
   Yes □ No □  
   a. If yes, include in file with the Employee Response to COVID-19 Questionnaire.

2. Did you review any and all publicly available social media accounts of the employee to document recent travel or social interaction? Yes □ No □  
   a. If any, print and include in file with the Employee Response to COVID-19 Questionnaire.

3. Did you inform all of Employee’s co-workers who were in close contact with the individual in the past 14 days of the Employee’s positive test/presumptive positive (without disclosing the Employee’s name)? Yes □ No □

4. Did you disinfect, pursuant to latest CDC guidelines, any and all workspaces and surfaces that the Employee had been in contact with over the past 14 days? Yes □ No □

5. Have you implemented the latest CDC and OSHA guidelines concerning maintaining a safe and healthy workplace, including any and all applicable PPE mandates?  
   Yes □ No □

6. Have you implemented the latest guidelines or mandates from any local or state regulatory body or government official applicable to your operations (i.e. state or county department of public health, local mayor’s order or state governor’s order)?  
   Yes □ No □