Employee Health Questionnaire

1. Have you experienced any COVID-19 symptoms in the last 24 hours? (Symptoms include: fever, cough, shortness of breath or difficulty breathing, chills, muscle pain, headaches, sore throat, new loss of taste or smells).

   Yes

   No

   If yes, please explain:

2. What is your temperature today? _____

3. Have you recently been in contact with anyone who has tested positive for COVID-19?

   Yes

   No

4. Have you recently traveled to a restricted area that is under a level 2, 3, or 4 Travel Advisory according to the U.S. State Department? Including: China, Italy, Iran, and most countries in Europe?

   Yes

   No

*I hereby certify that the above statements are true and correct. I understand that a false statement may result in a write up, or termination of employment.

Name (print): _____

Signature: _____

Date: _____