Employee Health Screening Form

Employee Information

Full Name

Employee ID

Department

Date

Health Screening Questions

1. Have you experienced any of the following symptoms in the past 14 days?

☐ Fever or chills ☐ Cough ☐ Shortness of breath or difficulty breathing ☐ Sore throat ☐ Loss of taste or smell ☐ None of the above

2. Have you had close contact with someone with a confirmed or suspected case of a communicable disease (such as COVID-19) in the last 14 days? Select...

3. Have you tested positive for a communicable disease (such as COVID-19) in the past 14 days?

Select...

Additional Comments / Notes

Employee Acknowledgement

☐ **I hereby certify that the above information is true and complete to the best of my knowledge.**

Employee Signature

Date