Health Screening Assessment

COVID-19 Questionnaire

Purpose: As mandated by New York State, this form must be completed daily by every employee to screen for possible exposure to the COVID-19 Virus. Answers will remain **confidential** in accordance with State and federal law, and maintained by your Departmental HR Representative(s).

Section 1	Employee Information	
Date:	First Name:	Last Name:
Department:		Work Location:
Phone:	Email:	

Section 2	Questions

Question 1:

In the past 14 days, have you tested positive for COVID-19?

Yes ☐ *-or-* No ☐

Question 2:

In the past 14 days, have you experienced symptoms of COVID-19 that you cannot attribute to another health condition?

(A list of potential symptoms can be found here: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html.)

Yes ☐ *-or-* No ☐

Question 3:

In the past 14 days, have you been in close contact (within 6 feet) for more than 10 minutes with anyone who has tested positive for COVID-19 in the last 14 days, or who has or had symptoms of COVID-19 in the last 14 days)?

Yes ☐ *-or-* No ☐

Question 4:

In the past 14 days, have you spent longer than a 24-hour period of time in a state that is, or was before you left the state, subject to quarantine restrictions on travelers arriving in New York State?

(A current list of travel restricted states can be found here: https://coronavirus.health.ny.gov/covid-19-travel-advisory.)

Yes ☐ *-or-* No ☐

Signature: *I hereby affirm that to the best of my knowledge, all answers above are true.*

Employee Name _____ Signature _____ Date _____

Immediately upon completion, please submit this form to your Departmental HR Representative(s).