

## Contractor<sup>1</sup> Health Assessment Form

Workplace safety remains one of the Company's highest priorities. To prevent the spread of COVID-19, we are conducting a simple screening questionnaire prior to entry to our workplace. Your participation is important to help us take precautionary measures to protect you and others in our facility.

Contractor Name:	Personal Phone Number (mobile/home):
Company/Organization:	Name of Host:
Date and time of entry:	

### Self-Declaration by Contractor

1	<p>Are you experiencing any of the following symptoms:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; padding: 5px;">Fever of 100.4 or higher<sup>2</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="width: 50%; padding: 5px;">Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 5px;">Sore throat <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="padding: 5px;">Abdominal pain <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 5px;">Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="padding: 5px;">New uncontrolled cough that causes difficulty breathing <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td style="padding: 5px;">New loss of taste or smell <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="padding: 5px;">New onset of a severe headache <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> </table>	Fever of 100.4 or higher <sup>2</sup> <input type="checkbox"/> Yes <input type="checkbox"/> No	Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sore throat <input type="checkbox"/> Yes <input type="checkbox"/> No	Abdominal pain <input type="checkbox"/> Yes <input type="checkbox"/> No	Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No	New uncontrolled cough that causes difficulty breathing <input type="checkbox"/> Yes <input type="checkbox"/> No	New loss of taste or smell <input type="checkbox"/> Yes <input type="checkbox"/> No	New onset of a severe headache <input type="checkbox"/> Yes <input type="checkbox"/> No
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2	<p>Have you tested positive for COVID-19?<sup>3</sup></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, when? _____ Date of last symptoms: _____</p>								
3	<p>Have you had close contact within the last 14 days with someone diagnosed with COVID-19 or who has experienced COVID-19 related symptoms?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>								
4	<p>Have you traveled outside of the state within the last 14 days?<sup>4</sup></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, where? _____</p>								

Signature (contractor): \_\_\_\_\_ Date: \_\_\_\_\_

**Note: This form must be completed each day you are on-site and reviewed by a Company representative to determine access to the facility. The information collected on this form will be used only to determine whether you can enter the workplace.**

**Access to facility (circle one):** **Approved**

**Denied**

<sup>1</sup> For businesses or operations in the construction industry, manufacturing facilities, research laboratories, meat and poultry processing plants, or casinos, daily entry screening protocols are required for all individuals entering the worksite (e.g., not only employees and contractors).

<sup>2</sup> For businesses or operations in the construction industry, manufacturing facilities, research laboratories, meat and poultry processing plants, casinos, temperature screening is required. Employer to review local public health orders to determine whether temperature screening is required.

<sup>3</sup> Follow **Return to Work Timing and Protocol** to determine when employee can return.

<sup>4</sup> Employer to review local public health orders to determine whether travel restrictions are required considerations; if not, this is optional.