Prior to the start of a shift all employees must complete the employee screening survey. If you answer "YES" to screening questions, do not report to work and contact your immediate supervisor

Full Name (First & Last) _____

Today's Date _____

Employee Symptom Check

Since your last day of work, have you experienced any of the following symptoms:

A new fever (100.4°F or higher) or a sense of having a fever?
A new cough that cannot be attributed to another health condition?
New shortness of breath or difficulty breathing that cannot be attributed to another health co
New chills that cannot be attributed to another health condition?
A new sore throat that cannot be attributed to another health condition?
New muscle aches (myalgia) that cannot be attributed to another health condition or specific activity (such as physical exercise)?
A new loss of taste or smell?
Contact with someone in the past 14 days with suspected or confirmed COVID-19?

☐ Yes or Y ☐ No or N

Days	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
June																											
July																											
August																											
September																											
October																											
November																											
December																											
January																											
February																											
March																											
April																											
May																											

any of the

ndition?

28	29	30	31