Screener Name (print): _______________________________ Screener Signature: _______________________________

Check One:
[ ] Employee  [ ] Student  [ ] Contractor  [ ] Vendor  [ ] Other______________________________

Area Visiting/Working:
[ ] Business Office  [ ] HR  [ ] Bookstore  [ ] IT  [ ] Library  [ ] Learning Lab  [ ] Cyber Lab

Student Services:  [ ] Admissions  [ ] Advising  [ ] Financial Aid  [ ] Testing


Print Name: _______________________________________________ Employee/Student ID: _________________

Email Address:  ______________________________________________ Phone: _____________________________

1. Are you ill or caring for someone who is ill?  [ ] Yes  [ ] No

2. I affirm that I have not had fever for at least (3) days and have not taken fever reducing medication during this time.  [ ] Yes  [ ] No

3. Do you have any of the following symptoms?
   - Cough  [ ]
   - Chills  [ ]
   - Headache  [ ]
   - Muscle Pain  [ ]
   - Sore Throat  [ ]
   - Loss of Taste or Smell  [ ]
   - Diarrhea  [ ]
   - Shortness of Breath or Difficulty Breathing  [ ]
   - Repeated Shaking with Chill  [ ]
   - Feeling feverish or a measured temperature greater than or equal to 100.0 degrees Fahrenheit  [ ]
   - Known close contact with a person who has been lab confirmed within the past 14 days to have COVID-19  [ ]
   - None of the above  [ ]

4. Will you require an accommodation because of one or more of the following high risk categories?  [ ] Yes  [ ] No
   - 65 or older  [ ]
   - Chronic Lung Disease  [ ]
   - Asthma  [ ]
   - Chronic Heart Disease  [ ]
   - Severe Obesity  [ ]
   - Diabetes  [ ]
   - Chronic Kidney Disease Undergoing Dialysis  [ ]
   - Liver Disease  [ ]
   - Weakened Immune System  [ ]
   - None of the above  [ ]

Complete Only if EE/Student returns after exhibiting symptoms:

5. Date Employee was sent home: _______________  Date Employee Returned to Work: _______________

6. My respiratory symptoms (cough and shortness of breath) have improved.  [ ] Yes  [ ] No  [ ] N/A
   Date respiratory symptoms began improving: ________________________________

7. At least ten days have passed since my fever and/or respiratory symptoms began  [ ] Yes  [ ] No  [ ] N/A
   Date fever and/or respiratory symptoms began: ____________________________

An employee sent home with a fever can return to work when:

- He or she has had no fever for at least three days without taking medication to reduce fever during that time; AND
- Any respiratory symptoms (cough and shortness of breath) have improved; AND
- At least ten days have passed since symptoms began.
- The employee may return to work earlier if a doctor confirms the cause of the employee's fever or other symptoms is not COVID-19 and provides a written release for the employee to return to work.

Signature _______________________________ Date: ____________________________