**SAMPLE**

**DAILY[[1]](#footnote-1) COVID-19 SELF-ASSESSMENT**

At **[COMPANY]**, we are committed to our employees’ health and well-being. Consistent with this commitment, all employees **[OPTIONAL: and visitors]** must truthfully complete the below COVID-19 self-assessment before leaving home for work[[2]](#footnote-2) **[OR: upon entry into our facility]**. **[OPTIONAL: In addition, a member of management will take your temperature when you arrive at the work site.]**.

Since my last shift / day of work[[3]](#footnote-3), I haveexperienced the following symptoms[[4]](#footnote-4):

**Yes No**

A temperature of 100.4 degrees or higher

Cough

Shortness of breath / difficulty breathing

Chills

Muscle pain

Sore throat

New loss of taste or smell

Gastrointestinal symptoms, such as nausea, vomiting, or diarrhea

Since my last shift / day of work, I have received a positive COVID-19 diagnosis.

Since my last shift / day of work, I have been in close contact with someone who has received a positive COVID-19 diagnosis.

[If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

Since my last shift / day of work, I have travelled out-of-state.

[If so, please identify city/state or non-U.S. city/country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_]

Employees who have checked any of the boxes above must contact their supervisor and Human Resources prior to reporting to work **[OR: will be denied entry to our facility]**. **[OPTIONAL: If you are a visitor, please call the department or division that you were planning to visit to discuss rescheduling]**.

Thank you for your cooperation in helping us stop the spread of COVID-19.

**By signing below, you certify that your answers to the questionnaire are true to the best of your knowledge, and that you understand and acknowledge that this information will be used solely to determine your fitness for duty consistent with [COMPANY]’s efforts to ensure a safe workplace. You further understand and acknowledge that this information will be shared with members of management or HR on a need-to-know basis, and any medical information will be maintained in a separate confidential medical file. You also certify that you will inform your manager or Human Resources immediately if your answer to any of the questions above changes.**

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. NOTE: Employers may have employees complete this assessment daily, periodically (i.e., weekly), or a single time upon return to work after furlough, leave of absence, etc. [↑](#footnote-ref-1)
2. NOTE: Employers may have employees complete this assessment at home prior to reporting to work, or upon entry to the facility. [↑](#footnote-ref-2)
3. NOTE: If this form will be used for visitors as well as employees, this language should be changed to “Within the last 14 days…” [↑](#footnote-ref-3)
4. NOTE: Symptoms included are consistent with the [CDC Guidance](https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html) as of 5/15/2020. Revisions to this list may be needed to reflect updated guidance. [↑](#footnote-ref-4)