



COVID-19 Exposure Questionnaire

1. How did you become aware that you were potentially exposed to COVID-19?

Prolonged close exposure for 15 or more minutes with a person who was diagnosed with COVID-19 within the last 14 days

Your lab confirmed COVID-19 diagnosis

Other _____

2. If any of the above apply, have you potentially exposed others during this time? Please explain (who, what, how)

3. When were you potentially exposed to COVID-19?

4. Where were you potentially exposed to COVID-19?

5. Are you currently experiencing or have in the past 14 days any of the symptoms listed below? (check all that apply)

Fever greater than 100.4 degrees

Difficulty Breathing

If yes, date symptoms first appeared:

Cough

Fatigue

Diarrhea

New loss of taste or smell

Muscle or body aches

Headache

Nausea or Vomiting

Sore Throat

Congestion

All of the above

None of the above

6. *Have you received the COVID-19 vaccine in the last 1 - 3 days? Yes No

*The following symptoms may be caused by the vaccine: fever, fatigue, headache, chills, muscle and body aches.

For Supervisors Use Only

Which of the following apply:

- Work From Home
- Quarantine (Not Working) – 14 Days
- Isolation (Not Working)
- Work at Usual Location (with a Mask – 14 Days)
- Work at Usual Location

Leave Status:

Leave Start Date:

Projected Return Date:

Date:

Employee Name:

Employee ID:

Supervisor Name:

Supervisor Signature:

****If placed on Quarantine or Isolation, please provide this form to an HR representative. If you have not utilized EPSL previously you may be eligible for Relief of Duty with pay.****

