Agency Healthcare Professional COVID-19 Screening

Name: _____ **Date:** _____

QUESTIONNAIRE (All three questions below must be answered for the form to be considered complete)

1. Have you recently traveled abroad outside of the United States?

□ Yes (Please answer question 1a)
□ No (Skip to question 2)

1a. Date you returned to the United States following your travel to the level 3 health notice country: _____/_____/_____

2. Have you come into close contact (within 6 feet) of someone who has a laboratory confirmed COVID-19 diagnosis in the past 14 days, WITHOUT wearing proper personal protective equipment?

□ Yes
□ No

3. Have you had a fever (greater than 100.4 or 38.0 C) AND/OR symptoms of lower respiratory illness such as cough, shortness of breath, or difficulty breathing in the past 24 hours?

□ Yes
□ No

Any additional comments you would like to add?

Please be aware that each healthcare facility you work at may have further specific requests such as:

- They may ask to take your temperature before starting your shift
- They may ask you to demonstrate your handwashing technique
- They may ask you to demonstrate proper use of Personal Protective Equipment

If any of the above information changes once you have submitted the form, please contact your Staffing Specialist immediately or our COVID-19 direct line at (712) 566-1186 for further instructions.

Your signature: _____ **Date:** _____