COVID-19 EMPLOYEE SELF-CERTIFICATION FORM

We are asking **all field employees** to complete and submit this self-certification every day. This is to continue taking safety measures; we are taking an abundance of caution to be sure you, your family, co-workers, and clients are safe. Prior to starting a shift, each employee shall self-certify. To ensure confidentiality please email your completed certification **daily** directly to your **manager** and **Laura Feldman**

- ☐ I have <u>no signs</u> of fever or a measured temperature above 100.3 degrees or greater, a cough or trouble breathing within the past 24 hours.

- ☐ I have not experienced <u>one or more</u> of the following symptoms within the past 24 hours: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, gastrointestinal problems (such as nausea, diarrhea, and vomiting), or new loss of taste or smell.

- ☐ I have <u>not</u> had "close contact" with an individual diagnosed with COVID-19.

- ☐ "Close Contact" means living in the same household as a person who has tested positive for COVID-19, caring for a person who has tested positive for COVID-19, being within 6-feet of a person who has tested positive for COVID-19, or coming in direct contact with secretions (e.g. sharing utensils, being coughed on etc.) from a person who has tested positive for COVID-19, while that person was symptomatic.

- ☐ I have <u>not</u> been asked to self-isolate or quarantine by doctor or a local public health official.

- ☐ I will use all available personal protective equipment (PPE), including face coverings throughout the workday.

NOTE: Employees exhibiting symptoms or unable to self-certify will be directed to leave the work site and seek medical attention and applicable testing by their health care provider. They are not to return to the work site until proper information is provided directly to Feldman. We want to be sure we are following the guidance from local, state and federal agencies for your safety and others.

By entering my name in the box below, I attest that the above information is accurate and complete. I understand this will be placed in my medical file.

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