COVID-19 Model Return to the Workplace Questionnaire

May 21, 2020
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This questionnaire is designed to be distributed to employees prior to their return to the workplace. This policy should be tailored to reflect your particular business needs. Please note that the way you modify the policy may implicate employment laws. For help tailoring the policy to your business, please contact your HEC Human Resources Consultant.

**COVID-19 Model Return to the Workplace Questionnaire**

[Date]

1. Have you tested positive for COVID-19?  Yes ___  No _____
   a. If your answer is “Yes,” have you been approved to return to work by your health care provider?  Yes ____  No _____

2. Within the last 14 days, have you had “close contact” (were within 6 feet or less of the individual for 10 minutes or more) with someone who has tested positive for COVID-19 and has not made a full recovery, or someone you believe may have COVID-19?  
   Yes ___  No _____

3. Have you recently experienced any of the following symptoms?  (Please check all applicable)
   ___  Cough
   ___  Shortness of breath, difficulty breathing, chest tightness
   ___  Fever
   ___  Chills
   ___  Sore throat
   ___  Muscle pain or body aches
   ___  New loss of sense of smell or taste
   ___  Nausea, diarrhea, or other gastrointestinal distress

   If you have experienced one or more of the above symptoms, when was the last date you experienced such symptoms?  ________________

4. Have you, or a member of your household, returned from domestic or foreign travel within the past 14 days?  
   Yes ____  No _____

5. Do you have a health condition which would make it difficult for you to wear a face covering (such as a simple cloth mask) in the workplace?  
   Yes _____  No _____
6. Are you concerned about returning to work in the office once state and local stay-at-home orders have been lifted, and government officials approve the re-opening of our workplace?
   Yes _____      No _____

   If your answer is “Yes,” please identify the nature of your concern (if other than child care):
   ____ I am concerned about the general safety of working at my workplace because of the pandemic.
   ____ I am in a high risk group for COVID-19 infection (such as pregnant women, persons with compromised immune systems, persons with chronic health conditions, or am over age 65).
   ____ Other. Please explain the nature of your concern: ________________________________
   ____________________________________________________________________________
   ____________________________________________________________________________

7. Do you have child care responsibilities that would make it difficult for you to return to work in the office? If so, please describe the hours/times which you would be available to work in the office:
   ______________________________________________________________________________

8. Do you generally rely on public transportation to get to work? Yes _____   No ______

9. Do you have a thermometer at home which you could use to take your own temperature on a daily basis?
   Yes _____   No _____

10. Are there any other concerns you have about returning to work at the present time?
    ______________________________________________________________________________
    ______________________________________________________________________________
    ______________________________________________________________________________

Print name: ____________________________
Signature: ____________________________    Dated: _____________