

Health Assessment Form

Workplace safety remains one of the Company's highest priorities. To prevent the spread of COVID-19, and reduce the potential risk of exposure to our employees and visitors, we are conducting a simple screening. Your participation is important to help us take precautionary measures to protect you and others in our facility.

Name:	Personal Phone Number (mobile/home):
Date and time of entry:	

Self-Declaration																									
1.	<p>Are you experiencing any of the following symptoms¹:</p> <p>A.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Fever of 100.4 or higher²</td> <td style="width: 33%;">Uncontrolled cough</td> <td style="width: 33%;">Shortness of breath</td> </tr> <tr> <td>Yes No</td> <td>Yes No</td> <td>Yes No</td> </tr> </table> <p>B.</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%;">Loss of taste or smell</td> <td style="width: 33%;">Muscle aches</td> <td style="width: 33%;">Sore throat</td> </tr> <tr> <td>Yes No</td> <td>Yes No</td> <td>Yes No</td> </tr> <tr> <td>Severe headache</td> <td>Diarrhea</td> <td>Vomiting</td> </tr> <tr> <td>Yes No</td> <td>Yes No</td> <td>Yes No</td> </tr> <tr> <td>Abdominal Pain</td> <td></td> <td></td> </tr> <tr> <td>Yes No</td> <td></td> <td></td> </tr> </table>	Fever of 100.4 or higher ²	Uncontrolled cough	Shortness of breath	Yes No	Yes No	Yes No	Loss of taste or smell	Muscle aches	Sore throat	Yes No	Yes No	Yes No	Severe headache	Diarrhea	Vomiting	Yes No	Yes No	Yes No	Abdominal Pain			Yes No		
Fever of 100.4 or higher ²	Uncontrolled cough	Shortness of breath																							
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2.	<p>Have you tested positive for COVID-19?</p> <p>Yes No</p> <p>If yes, when? _____ Date of last symptoms: _____</p>																								
3.	<p>Have you had close contact within the last 14 days with someone diagnosed with COVID-19 or who has experienced COVID-19 related symptoms?</p> <p>Yes No</p>																								
4.	<p>Have you traveled outside of the state within the last 14 days?³</p> <p>Yes No If yes, where? _____</p>																								

Signature: _____

Date: _____

Note: This form must be completed each day you are on-site and reviewed by a company representative to determine access to the facility. The information collected on this form will be used only to determine whether you can enter the workplace. Any affirmative responses to the above questions must be reviewed immediately. Do NOT enter the workplace if you have responded yes to any question until you are evaluated and receive further direction. Please email this completed form to healthassess@mphi.org.

Access to facility (circle one): **Approved**

Denied

¹ Under EO 2020-172, an individual is considered to be displaying symptoms of COVID-19 when experiencing: (1) any one section "A" symptom, or at least two section "B" symptoms, and (2) the symptoms are not explained by a known medical or physical condition.

² For businesses or operations in the construction industry, manufacturing facilities, research laboratories, meat and poultry processing plants, casinos, temperature screening is required. In other industries, employer to review local public health orders to determine whether temperature screening is required. If not, temperature screening is optional.

³ Employer to review local public health orders to determine whether travel restrictions are required considerations; if not, this is optional.