

# Employee Symptom Report

**(to be completed by Supervisor when an employee reports having symptoms)**

Employee Name: \_\_\_\_\_

Symptoms (please list):

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Date that symptoms started: \_\_\_\_\_

Last date that employee worked onsite: \_\_\_\_\_

\*Symptoms confirmed to be consistent with COVID-19? (Yes or No): \_\_\_\_\_

Employee has been instructed to use Symptom Monitoring Log (Yes or No): \_\_\_\_ Date: \_\_\_\_\_

What other employees/people has employee had close contact with(at least 10 minutes within 6 feet)?

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(list others on back, if applicable)

People listed above have been instructed to use Symptom Monitoring Log (Yes or No): \_\_\_\_ Date: \_\_\_\_\_

Did employee have contact with someone confirmed to have COVID? (Yes or No): \_\_\_\_\_

Does employee work in direct patient care, or in a critical position for continued operations? (Yes or No): \_\_\_\_\_

***Please return this form to HR***

**For HR documentation:**

Flu Test date: \_\_\_\_\_

COVID Test date: \_\_\_\_\_

Received Symptom Log (Y/N) \_\_\_\_

Flu Test result: \_\_\_\_\_

COVID Test result: \_\_\_\_\_

Return to work date: \_\_\_\_\_