COVID-19 Health Reporting Form for Remote Workers

Full Name

Date

Email Address

Are you currently experiencing any of the following symptoms?

- [ ] Fever or chills
- [ ] Cough
- [ ] Shortness of breath or difficulty breathing
- [ ] Unusual fatigue
- [ ] Loss of taste or smell
- [ ] Sore throat
- [ ] None of the above

Have you tested positive for COVID-19 in the past 10 days?

- ( ) Yes
- ( ) No

Have you been in close contact with anyone who has tested positive for COVID-19 in the past 10 days?

- ( ) Yes
- ( ) No

Additional comments or concerns