# Subcontractor COVID-19 Exposure Self-Assessment Form

## Personal Information

Full Name

Company Name

Date

Phone Number

Email Address

## Health Screening Questions

1. Have you experienced any of the following symptoms in the past 14 days?

- [ ] Fever or chills
- [ ] Cough
- [ ] Shortness of breath or difficulty breathing
- [ ] Fatigue
- [ ] Other:

2. Have you been in close contact with anyone who has tested positive for COVID-19 within the past 14 days?

- ○ Yes
- ○ No

3. Have you been diagnosed with COVID-19 in the past 14 days?

- ○ Yes
- ○ No

4. Are you currently awaiting the results of a COVID-19 test?

- ○ Yes
- ○ No

5. Have you traveled internationally in the past 14 days?

- ○ Yes
- ○ No

## Certification

- [ ] I certify that the information provided is accurate to the best of my knowledge.

Signature

Date