

Please complete the following questions before beginning your work today.

Name: _____ Date: _____ Time: _____

Phone #: _____ Email: _____

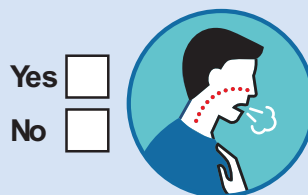
Do you have any of the following (new or worsening):



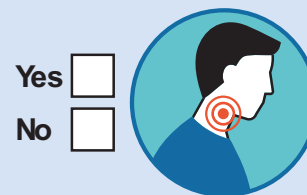
Fever/Chills



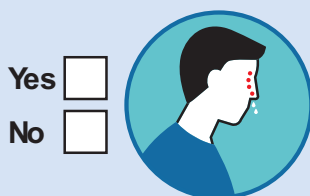
Cough



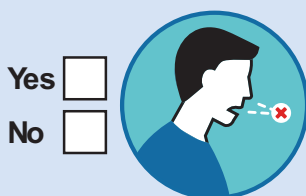
Difficulty breathing or
shortness of breath



Sore throat,
trouble swallowing



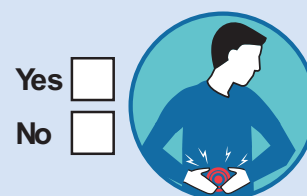
Runny nose/stuffy
nose or nasal
congestion



Decrease or loss of
taste or smell



Not feeling well,
extreme tiredness,
sore muscles



Nausea, vomiting,
diarrhea, abdominal
pain

Yes Have you been in close contact with someone who is
No sick or has confirmed COVID-19 in the past 14 days?

Yes Have you returned from travel outside Canada in the
No past 14 days?

If you answered YES to any of these questions, go home and self-isolate immediately. Contact Telehealth Ontario (1-866-797-0000) or your health care provider to determine if you require a COVID-19 test.

Keep in contact with your Supervisor to provide status updates.