



## OHS DECLINATION FORM

**Employer (please check)**

- NYC H+H
- Affiliate \_\_\_\_\_
- Agency / Vendor
- Community Care / At Home
- Correctional Health Services
- Gotham Health
- MetroPlus
- Other
- Post-Acute
- Volunteer

**CLIENT NAME:** \_\_\_\_\_

I understand that my occupational exposure to the following preventable diseases puts me at risk of acquiring the disease(s). I choose to decline the vaccination(s) / screening checked below at this time. I understand that by declining the vaccination(s) / screening, I continue to be at risk of acquiring the disease(s) and spreading it to others.

Check vaccine(s) / screening to be declined:

- Influenza  Hepatitis B Vaccine  Hepatitis C screening  HIV Screening  Meningococcal  Mumps
- Tetanus Diphtheria (Td)  Tetanus / Diphtheria / Pertussis (Tdap)  Varicella

**Employee Name (Print)**

**Witness Name (Print)**

**Employee Signature**

**Witness Signature**

**Date**

HH 2968 (June 2024)

## Instructions for Completing Form HH 2097A

This form is to be completed by candidates or eligible rehired personnel with \*persistent presence in health care facilities.

### 1. OHS Pre-Placement Health Assessment Form (HH 2097A)

#### a. Number of pages 5

- i. Page 1 – To be completed by Candidate or Eligible Rehired Personnel
  - Answer all sections. If not applicable, write N/A
  - Answer all YES/NO questions in Health Assessment Questionnaire
  - Sign the attestation at bottom of page 1
- ii. Pages 2 and 3 – To be completed by Candidate or Eligible Rehired Personnel
  - Fill in Name and Date of Birth (DOB) at top of page
  - Answer all YES/NO questions in Past Medical History, Baseline Individual TB Risk Assessment, Substance Use Attestation/Testing (as applicable), and Bloodborne Pathogens sections
  - Include all allergies to medications, food, latex and environmental agents
  - Sign both attestations on page 3
- iii. Page 4 – To be completed by By Medical Provider ONLY, using documents provided by the Candidate or Eligible Rehired Personnel
- iv. Page 5 – To be completed by Candidate or Eligible Rehired Personnel and OHS Facility Fit Testing Staff ONLY
  - Fill in Name and DOB at top of page
  - Complete Respirator Fit Test Medical Evaluation if your job requires you to use a Respirator Mask (N95)
  - Answer questions 1-3 and sign attestation
  - Sign appropriate attestation at the bottom of page 5 [**Note:** If fit tested, attestation to be signed on date fit test completed or performed]

#### **\*Persistent Presence:**

Refers to those personnel whose assigned workplace is in a health care setting. Also refers to personnel who have recurring interactions with patients and direct care providers who work at a health care facility, at least two times per month every month each year. Includes all personnel who are providing clinical care.

All other personnel lack persistent presence.

**OCCUPATIONAL HEALTH SERVICES (OHS)  
PRE-PLACEMENT HEALTH ASSESSMENT FORM  
PERSONNEL WITH PERSISTENT PRESENCE IN HEALTHCARE FACILITIES**

Clear Form



**CANDIDATE OR ELIGIBLE REHIRED PERSONNEL INFORMATION**

<b>Last Name:</b>	<b>Middle Name:</b>	<b>First Name:</b>
<b>Other Name Used (Preferred Name):</b>		
<b>Empl ID: (required)</b>	<b>Date of Birth:</b>	
<b>Home Address:</b>		
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Email Address: (Personal)</b>
<b>Cell Phone:</b>		<b>Email Address: (Work)</b>

**JOB INFORMATION**

<b>My role requires me to visit a facility and have regular in-person interactions with patients and staff at least twice a month, every month throughout the year.</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Employer (please check)</b>	<b>Work Site Location:</b>	
<input type="checkbox"/> NYC H+H <input type="checkbox"/> Volunteer <input type="checkbox"/> Affiliate _____ <input type="checkbox"/> Other _____	<input type="checkbox"/> Central Office <input type="checkbox"/> 100% Remote <input type="checkbox"/> Acute Care Facility <input type="checkbox"/> Gotham Health	
	<input type="checkbox"/> Post-Acute Care Facility <input type="checkbox"/> Correctional Health Services	
<b>Position/Job Title:</b>	<b>Supervisor's Name:</b>	
	<b>Phone:</b>	
<b>Department:</b>	<b>Unit / Clinic:</b>	

**EMERGENCY CONTACT**

<b>Last Name:</b>	<b>First Name:</b>	<b>Relationship:</b>	<b>Telephone:</b>
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**HEALTH ASSESSMENT QUESTIONNAIRE**

**Do you have any of these conditions? Please Check YES or NO**

Anemia/Blood Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma / Lung Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Immune Disease (Deficiency or Auto-Immune)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disease/Urinary Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures/Epilepsy/Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach/Intestinal/Liver Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vision or Hearing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other Medical Conditions not listed above:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have chronic pain or limited motion in your Joints, Muscles, Neck or Back? <b>If yes, please explain:</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**I acknowledge that NYC Health + Hospitals ("System") can contact me by e-mail or phone about Occupational Health matters.**

**Candidate Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**PAST MEDICAL HISTORY**

Please Check YES or NO

Have you had any chronic illnesses, hospitalizations, or injuries in the past that may interfere with the performance of your job duties? <b>If yes, please explain:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had any surgeries / operations in the past that may interfere with the performance of your job duties? <b>If yes, please explain:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you allergic to any medicines, foods, latex or environmental agents? <b>If yes, please explain:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently under modification of your job duties or have a reasonable accommodation from Equal Employment Opportunity (EEO)? <b>If yes, please explain:</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Start Date: _____ End Date: _____	
Are you in need of a modification of your job duties or otherwise in need of a reasonable accommodation? If yes, you must contact the Office of EEO.	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Baseline Individual TB Risk Assessment (Please check YES or NO)**

Do you have any symptoms suggestive of active tuberculosis? i.e., prolonged (>3 weeks) unexplained fever, prolonged cough, hemoptysis, unintended weight loss or drenching night sweats?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you resided in a tuberculosis endemic area for >1 month since the last screening? (i.e., any country other than Australia, Canada, New Zealand, the United States, or those in western or northern Europe)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an immunocompromising condition, or one that requires immunosuppression, including HIV infection, receipt of an organ transplant, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone $\geq 15$ mg/day for $\geq 1$ month), or other immunosuppressive medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had close contact with someone who has active tuberculosis without the use of a fit-tested N95 respirator?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been involved with the performance of any cough inducing or aerosol generating procedures (e.g., sputum induction or bronchoscopy*) without the use of a fit-tested N95 respirator? <i>*NYC Health + Hospitals defines the list of aerosol-generating procedures in the "GUIDANCE: AEROSOLIZED GENERATING PROCEDURES", DOC ID: HHCMPA232020</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Substance Use Screening (as applicable)**

Have you been concerned about, diagnosed, or treated for substance use in the past 3 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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**Bloodborne Pathogens (Please check YES or NO)**

Have you ever been diagnosed with Hepatitis B or C or HIV? (Circle infection)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Disclose
Have you taken medication to treat Hepatitis B or C or HIV? (Circle infection)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Decline to Disclose
Have you received Hepatitis B vaccines?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Would you like to be tested for Hepatitis B or C or HIV (Non-mandatory/Voluntary)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**HEPATITIS B VACCINE DECLINATION STATEMENT**

If you have never received Hepatitis B vaccines or are found to be not immune to Hepatitis B, you are eligible to receive free vaccines in OHS.

Do you wish to receive free Hepatitis B vaccines?     Yes     No

**If no, read and sign below.**

**HEPATITIS B VACCINE DECLINATION STATEMENT**

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B vaccine, at no charge to myself. However, I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to myself.

**Candidate Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Clinician Witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**HEALTH STATUS ATTESTATION**

I attest that: I am free from a health impairment which might interfere with the performance of my job duties with or without a reasonable accommodation, including no evidence of substance use. I understand that OHS maintains my OHS record and shall provide all additional instructions regarding job related issues and follow-up, as required. The above information is true and accurate as reflected in the Terms and Conditions of Employment.

**Candidate Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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Clear Form



Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**FOR MEDICAL PROVIDER USE ONLY**

Height:	Weight:	BMI:	BP:	Pulse:	Respirations:	Temp:
Physical Exam	Normal	Abnormal	Explain Abnormality			
Skin	<input type="checkbox"/>	<input type="checkbox"/>				
HEENT	<input type="checkbox"/>	<input type="checkbox"/>				
Cardiac	<input type="checkbox"/>	<input type="checkbox"/>				
Lung	<input type="checkbox"/>	<input type="checkbox"/>				
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>				
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>				
Neuro	<input type="checkbox"/>	<input type="checkbox"/>				
Extremities	<input type="checkbox"/>	<input type="checkbox"/>				

**TB Testing - IGRA test done within 3 months of start date. Attach copy of original lab reports showing name of laboratory, laboratory director and chest x-ray report if TB test is positive.**

TEST	DATE	
QuantiFERON	Enter Date	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminant
T Spot	Enter Date	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Invalid <input type="checkbox"/> Borderline
If positive TB test, Chest X-ray required	Enter Date	Result: _____ LTBI Treatment completed: <input type="checkbox"/> Yes <input type="checkbox"/> No

**TITERS / LABS (Attach copy of original Lab Reports showing name of Laboratory and Lab Director)**

TEST	DATE	IMMUNE	SUSCEPTIBLE	INDETERMINANT
<input type="checkbox"/> Rubeola/Measles IgG	Enter Date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Mumps IgG	Enter Date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rubella IgG	Enter Date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Varicella IgG	Enter Date	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> HBsAb	Enter Date	Result: _____		
<input type="checkbox"/> HBsAg (as clinically indicated)	Enter Date	Result: _____		
<input type="checkbox"/> anti-HBcAb (as clinically indicated)	Enter Date	Result: _____		
<input type="checkbox"/> HCV RNA PCR (as clinically indicated)	Enter Date	Result: _____		
<input type="checkbox"/> HIV Viral Load (as clinically indicated)	Enter Date	Result: _____		
<input type="checkbox"/> HBV Viral Load (as clinically indicated)	Enter Date	Result: _____		

**VACCINES (Proof of Vaccination)**

MMR (Two doses 4 weeks apart)	1 <sup>st</sup> Dose Date: _____	2 <sup>nd</sup> Dose Date: _____
Varicella (Two doses 4 weeks apart)	1 <sup>st</sup> Dose Date: _____	2 <sup>nd</sup> Dose Date: _____
<input type="checkbox"/> Hepatitis B Series: <input type="checkbox"/> Heplisav-B (Two doses) <input type="checkbox"/> Engerix B (Three doses)	1 <sup>st</sup> Dose Date: _____	2 <sup>nd</sup> Dose Date: _____ 3 <sup>rd</sup> Dose Date: _____
<input type="checkbox"/> TD <input type="checkbox"/> Tdap (within last 10 years)	Enter Date _____	
<input type="checkbox"/> Meningococcal (for Microbiology Lab Personnel only)	Vaccine Product: _____	Date: _____
	Vaccine Product: _____	Date: _____
<input type="checkbox"/> Influenza (annually)	Date of most recent vaccine: _____	

**OTHER TESTS (toxicology results ONLY accepted from these labs: Alere, CRL, LabCorp, MedTox or Quest)**

Color Vision Screening (for Lab Personnel and as applicable)	<input type="checkbox"/> Normal	<input type="checkbox"/> Deficient	<input type="checkbox"/> Color blind
Visual Acuity	<input type="checkbox"/> With corrective lenses	<input type="checkbox"/> Without corrective lenses	Rt _____/20 Lt _____/20
*Urine Toxicology (within 30 days)	<input type="checkbox"/> PASS	<input type="checkbox"/> FAIL (Must attach Lab Results)	Date: _____
Fit Testing result (N95):	<input type="checkbox"/> PASS	<input type="checkbox"/> FAIL	<input type="checkbox"/> N/A (Please attach the documentation. See next page)
PAPR/CAPR Training (as applicable):	<input type="checkbox"/> PASS	<input type="checkbox"/> FAIL	Date: _____ Trainer's Name: _____

\*As applicable; **Note:** All motor vehicle operators must undergo toxicology testing.

**MEDICAL CLEARANCE CERTIFICATION**

**PLAN:**  Drug Toxicology  Mumps IgG  Measles IgG  Rubella IgG  HBsAb  
 Td/Tdap  QFT  CXR  Flu Vaccine  Other (Please specify): \_\_\_\_\_

Based on this evaluation, can this individual be granted medical clearance?  Yes  No  Pending

Provider/ Designee Name: \_\_\_\_\_ License Number: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**Last Name:** \_\_\_\_\_ **First Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**RESPIRATOR FIT TEST MEDICAL EVALUATION**

1. Have you ever worn or been fit-tested for a respirator mask? <b>If yes, please list the name and size of the mask:</b> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Did you have any problem wearing the respirator mask? <b>If yes, please explain:</b> _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Did you have any of the following:		
a. Emphysema, COPD or chronic lung disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Uncontrolled Asthma or unexplained difficulty breathing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Have you been told by your doctor that you have an irregular heartbeat or rhythm?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Have you been told by your doctor that you have angina or other serious heart conditions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I attest that the answers I have provided on this form are true to the best of my knowledge. I understand that if I knowingly provide false information, it may affect my health.

**Candidate Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PROVIDER ASSESSMENT:**     CAN be fit tested                       CANNOT be fit tested                       CAPR/PAPR trained  
 Needs further evaluation  
 Not applicable due to 100% REMOTE work status or FACILITY location

**Provider/ Designee Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**FIT TESTING RESULTS:**     Qualitative Seal Check:                      FIT TEST:  PASS     FAIL  
 Quantitative:    FIT TEST:  PASS     FAIL

**Mask Type:** \_\_\_\_\_ **Size:** \_\_\_\_\_

**Fit Tester Name:** \_\_\_\_\_ **Fit Tester Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I attest that I was fit tested today for a respirator mask. I received training on how to put on the mask and proper use of the mask.

**Candidate Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I attest that I was NOT fit tested today for a respirator mask.

**Candidate Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Tuberculosis: General Information (HH 2944)

## What is TB?

Tuberculosis (TB) is caused by a bacterium called *Mycobacterium tuberculosis*. The bacteria usually attack the lungs, but TB bacteria can attack any part of the body such as the kidney, spine, and brain. Not everyone infected with TB bacteria becomes sick. As a result, two TB- related conditions exist: latent TB infection (LTBI) and TB disease. If not treated properly, TB disease can be fatal.

## What are the symptoms of TB?

Symptoms of TB disease depend on where in the body the TB bacteria are growing, TB bacteria usually grow in the lungs (pulmonary TB). TB disease in the lungs may cause symptoms such as a bad cough that lasts 3 weeks or longer; pain in the chest; coughing up blood or sputum (phlegm from deep inside the lungs). Other symptoms of TB disease are weakness or fatigue, weight loss, no appetite, chills, fever, and sweating at night. Symptoms of TB disease in other parts of the body depend on the area affected, People who have latent TB infection do not feel sick, do not have any symptoms, and cannot spread TB to others.

## How is TB Spread?

TB germs are put into the air when a person with TB disease of the lungs or throat coughs, sneezes, speaks or sings. It is important to know that a person who is exposed to TB bacteria is not able to spread the bacteria to other people right away. Only persons with active TB disease can spread TB bacteria to others. Before you would be able to spread TB to others, you would have to breathe in TB bacteria and become infected. Then the active bacteria would have to multiply in your body and cause active TB disease. At this point, you could possibly spread TB bacteria to others. People with TB disease are most likely to spread the bacteria to people they spend time with every day, such as family members, friends, coworkers, or schoolmates. Some people develop TB disease soon (within weeks) after becoming infected, before their immune system can fight the TB bacteria. Other people may get sick years later, when their immune system becomes weak for another reason. Many people with TB infection never develop TB disease.

## What is the Difference between Latent TB Infection (LTBI) and TB Disease?

TB bacteria can live in the body without making you sick. This is called latent TB infection. In most people who breathe in TB bacteria and become infected, the body is able to fight the bacteria to stop them from growing. People with latent TB infection have no symptoms, don't feel sick, can't spread TB bacteria to others, usually have a positive TB skin test reaction or positive TB blood test, and may develop TB disease if they do not receive treatment for latent TB infection.

TB bacteria become active if the immune system can't stop them from growing. When TB bacteria are active (multiplying in your body), this is called TB. disease. People with TB disease are sick. They may also be able to spread the bacteria to people they spend time with every day. Many people who have latent TB infection never develop TB disease. Some people develop TB disease soon after becoming infected (within weeks) before their immune system can fight the TB bacteria, Other people may get sick years later when their immune system becomes weak for another reason. For people whose immune systems are weak, especially those with HIV infection, the risk of developing TB disease is much higher than for people with normal immune systems.

## What Should I do if I think I Have TB Disease or Show Signs/Symptoms of TB Disease?

If you think you have TB Disease or have a history of LTBI and are exhibiting signs/symptoms listed above, you must contact OHS immediately.

## What Should I do if I Have Spent time with Someone with Latent TB Infection (LTBI)?

A person with LTBI cannot spread germs to other people. You do not need to be tested if you have spent time with someone with latent TB infection. However, if you have spent time with someone with TB disease or someone with symptoms of TB, you should contact OHS immediately.

## What Should I do if I Have Been exposed to someone with TB Disease?

People with TB disease are most likely to spread the germs to people they spend time with every day, such as family members or coworkers. If you have been around someone who has TB disease, you should contact OHS immediately.

## How Do You Get Tested for TB?

There are two kinds of tests used to detect TB bacteria in the body: the TB skin test (TST) and TB blood tests. A positive TB skin test or TB blood test only tells that a person has been infected with TB bacteria. It does not tell whether the person has latent TB infection (LTBI) or has progressed to TB disease. Other tests, such as a chest x-ray and a sample of sputum, are needed to see whether the person has TB disease,

## Candidate Attestation

This letter attests that I have received the Tuberculosis: General Information Sheet.

Print Name \_\_\_\_\_

Signature \_\_\_\_\_

Facility Name \_\_\_\_\_ Date \_\_\_\_\_

**Information retrieved and modified from the CDC. Gov/TB website HH 2944 (Aug 22)**



## OHS Registration Information Form

PLEASE PRINT

Name: \_\_\_\_\_  
Last First

Date of Birth: \_\_\_\_\_

Maiden Name: \_\_\_\_\_

Address: \_\_\_\_\_

Apartment #: \_\_\_\_\_  
City State Zip code

Telephone Number: \_\_\_\_\_

Race: \_\_\_\_\_ Sex: ( ) F ( ) M

Title: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mother's Maiden name: \_\_\_\_\_

Place of Birth: \_\_\_\_\_ How long in U.S. \_\_\_\_\_

Religion: \_\_\_\_\_

### Insurance Information

Name of Insurance

Company: \_\_\_\_\_

Identification Number: \_\_\_\_\_

Authorization: \_\_\_\_\_

Referral: \_\_\_\_\_

COVID- 19 Assessment Form

Staff's Contact Information

Name: \_\_\_\_\_ Sex: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ TKID: \_\_\_\_\_

Contact phone number: \_\_\_\_\_

Personal Email: \_\_\_\_\_

Title: \_\_\_\_\_

Department: \_\_\_\_\_ Facility: \_\_\_\_\_

Full Address: \_\_\_\_\_

**Any signs and symptoms of following WITHIN THE LAST 14 DAYS?**

Fever (subjective or > 100 F)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Use of antipyretic medication	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cough	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Shortness of breath	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Diarrhea	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Muscle pain	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Sore throat	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Loss of taste or smell	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other: _____		

**Travel history WITHIN THE LAST 14 DAYS**

**Travel history WITHIN THE LAST 14 DAYS**  YES  NO

If yes, which country did you travel? \_\_\_\_\_

**Direct Contact with suspected or confirmed COVID 19 WITHIN THE LAST 14 DAYS**

Date of arrival to JFK: \_\_\_\_\_

YES  NO

If yes, please answer following questions

Brief contact (< 1-2 mins)  YES  NO

Close Contact  YES  NO

- Within 6 feet+2 meters for a prolong period of time
- Caring for, visiting or sitting within 6 feet in a health care waiting Area or room
- Unprotected direct contact infectious secretions (e.g. Being coughed on, touch used tissue with a bare hand)

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Staff Name

\_\_\_\_\_  
Date