Return to Work Daily Self-Screening Questionnaire
CHA03.018F1

This will be updated as the CDC and VA State Health Department's information on COVID-19 continues to change.

1. Within the last 14-days, have you or anyone in your household been diagnosed with COVID-19, had a fever at or above 100.4 °F, cough, difficulty breathing, or flu-like symptoms?

   ☐ YES ☐ NO

2. Are you currently providing care for anyone diagnosed with COVID-19, had a fever, cough, difficulty breathing, or flu-like symptoms?

   ☐ YES ☐ NO

3. Within the last 14 days, have you or anyone in your household experienced a loss of taste or smell?

   ☐ YES ☐ NO

4. Are you or anyone in your household currently under voluntary isolation?

   ☐ YES ☐ NO

5. Have you been in close contact (within 6 feet for 15 minutes or more, or having direct exposure to respiratory secretions) with someone suspected or confirmed to have COVID-19 in the last 14 days?

   ☐ YES ☐ NO

6. Have you or anyone in your household been under involuntary isolation in the last 14 days?

   ☐ YES ☐ NO

7. Have you or anyone in your household traveled internationally in the last 14 days?

   ☐ YES ☐ NO

If you answer YES to any of the above, do not enter the CHA office at this time. Thank you for your cooperation.