



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°, 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. Within the last 14 days, have you or anyone in your household been under involuntary isolation?
 YES NO

6. Within the last 14 days, have you or anyone in your household traveled internationally?
 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.