Protocol for Positive COVID-19 Diagnosis: Employee

Employee name: ____________________________________________

Program/agency: __________________________________________

Date of positive COVID-19 diagnosis: __________________________

Date of first symptoms: _____________________________________

Physical location(s) frequented since the onset of symptoms:
__________________________________________________________
________________________________________________________________
________________________________________________________________
________________________________________________________________

Potentially affected co-workers: ________________________________

________________________________________________________________
________________________________________________________________

Potentially affected persons served: _____________________________

________________________________________________________________
________________________________________________________________

Has employee consented to being identified as COVID-19 positive for purposes of follow-up with those exposed:
[ ] Yes   [ ] No    If yes, date consent obtained: ____________________________

Has the Health Department been notified of COVID-19 positive diagnosis?  [ ] Yes   [ ] No;
Date notified, if known: __________________________________________

Employee quarantine time period per health care provider: ____________________________

________________________________________________________________
________________________________________________________________

Action taken by employer (attached additional pages as necessary): ____________________________

________________________________________________________________
________________________________________________________________

________________________________________________________________

Original: Human Resources