Staff/ Professional Staff Screening Card

Trillium Health Partners
Better Together

1. Are you experiencing **any** of the following symptoms? (Check all that apply)

- ☐ Fever of 37.8 degree C.
- ☐ Shortness of breath
- ☐ Change or loss of sense of taste and/or smell
- ☐ Nausea/ vomiting, diarrhea, abdominal pain
- ☐ New or Worsening Cough
- ☐ Runny nose or nasal congestion
- ☐ Sore Throat and/or pain swallowing
- ☐ **No symptoms**

	YES	NO
2. Have you had close contact, including living in the same household, with a confirmed COVID-19 positive individual in last 14 days? *(sharing food, living in the same household, without PPE)*	☐	☐
3. Have you travelled outside of Canada within the last 14 days?	☐	☐
By completing and submitting this form, I attest to adhering to all current infection prevention and safety measures in accordance with the **Occupational Health and Safety Act, Trillium Health Partners (THP) Code of Conduct, THP Health and Safety Policy** and any other key policies or procedures.	☐	☐

If you are experiencing any of the symptoms listed above, please immediately notify your leader & EHSW.

DATE: _____ **Staff Name (Please Print)** _____

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