



South Central Region
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COVID-19 Health Screening Form

All employees or authorized visitors/vendors wishing to enter the home or all service delivery/office work sites, are required to answer and sign screening questions before starting the shift or visit.

If you answer YES to any of these questions, DO NOT enter the home or service delivery/work location, DO NOT begin your shift / report to work, DO NOT engage in contact with support recipients or other staff, and CONTACT your supervisor. You are strongly urged to contact your medical provider or TELADOC immediately.

| Questions | YES | NO |
|---|-----|----|
| Have you traveled in the last 3 weeks (21 days)? | | |
| Have you , or anyone you have had contact with, had symptoms of COVID-19 (or corona virus) or are being tested for COVID-19? | | |
| Has anyone in your household traveled, or have you been around anyone who has traveled in the last 3 weeks (21 days)? | | |
| Do you have or recently have had any of the following symptoms: | | |
| Fever | | |
| Cough | | |
| Loss of appetite | | |
| Significant fatigue | | |
| Diarrhea | | |
| Shortness of breath | | |
| Difficulty breathing | | |
| Muscle aches or pain | | |
| Chills | | |
| Repeated shaking with chills | | |
| Headache | | |
| Sore throat | | |
| Runny nose | | |
| Vomiting | | |
| New loss of sense of smell or altered taste | | |

I confirm my answers to the above questions. I understand that failure to provide true and accurate information may result in disciplinary action, up to and including separation of employment.

Signature: _____ Date: _____

Name: _____ Employee ID: _____ (as applicable)

Effective April 6, 2020; Latest revised May 13, 2020

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