EMPLOYEE HEALTH SCREENING QUESTIONAIRE

Date _____

My signature below signifies that I can answer no to the following statements. If I answer yes to ANY of them, please contact Jennifer immediately, in person or by phone 406-860-3610 as you may be asked to work remotely.

- Within the past 3 days have you had a NEW onset of any of the listed symptoms (felt feverish, cough, difficulty breathing, chills, body aches, sore throat, changes in your ability to taste or smell, unexplained headache, unexplained vomiting or diarrhea)?
- In the last 14 days has anyone in your household who has been diagnosed with COVID-19?
- Is there anyone in household WHO HAS SYMPTOMS of COVID19 awaiting test results?

Signature **Print Name**

_____

_____

_____

_____

_____

_____

_____

_____