REDWOODS
A CRUM & FORSTER COMPANY

Staff Return to Work Questionnaire

Name: _____ **Date:** _____

Location: _____

Manager: _____

Use this form ONLY for employees/workers coming on-site, NOT to be used for remote employees/workers.

EMPLOYEE HEALTH AND WELLNESS CHECKLIST

Are you experiencing any of the following symptoms or combinations of symptoms?	Yes	No	N/A	How long have you experienced these symptoms?	Comments
CDC – COVID-19 SYMPTOMS	❑	❑	❑		
Cough	❑	❑	❑		
Shortness of breath	❑	❑	❑		
Or at least two of these symptoms?	❑	❑	❑		
Fever (100.4 or higher)	❑	❑	❑		
Chills	❑	❑	❑		
Repeated shaking with chills	❑	❑	❑		
Muscle pain	❑	❑	❑		
Headache	❑	❑	❑		
Sore throat	❑	❑	❑		
New loss of taste/smell	❑	❑	❑		
Are you currently waiting for COVID-19 test results?	❑	❑	❑		

SOCIAL DISTANCING & EMPLOYEE EXPOSURE

Have you had any of these experiences?	Yes	No	N/A	Comments
Have you self-quarantined? If so, how many days and why? (Remaining in your home and outdoor activities without coming closer than 6 feet from others)	❑	❑	❑	_____ _____ _____
Have you been exposed to *anyone* currently waiting for COVID-19 test results?	❑	❑	❑	_____ _____
Have you been exposed to *anyone* who has tested positive for COVID-19?	❑	❑	❑	_____ _____

SOCIAL DISTANCING & EMPLOYEE EXPOSURE, CONTINUED

Have you been exposed to *anyone* with any of the following symptoms or combinations of symptoms?	**Yes**	**No**	**N/A**	**How long have they experienced these symptoms?**	**Comments**
CDC – COVID-19 SYMPTOMS	❑	❑	❑		
Cough	❑	❑	❑		
Shortness of breath	❑	❑	❑		
Or at least two of these symptoms?	❑	❑	❑		
Fever (100.4 or higher)	❑	❑	❑		
Chills	❑	❑	❑		
Repeated shaking with chills	❑	❑	❑		
Muscle pain	❑	❑	❑		
Headache	❑	❑	❑		
Sore throat	❑	❑	❑		
New loss of taste/smell	❑	❑	❑		
Have you traveled outside your state or regional area?	❑	❑	❑		

Do you have any additional information that is pertinent to you returning to the facility?

_____

_____

HUMAN RESOURCES USE ONLY

Notes: