COVID-19 Incident Report Form

Date of COVID-19 test _____

Estimated Date of COVID-19 Possible Exposure: _____

Name of Employee: _____

Home Address: _____

_____

Phone Numbers: (c) _____ (h) _____ (w) _____

Date of Birth: _____ S or U number:

_____

Employee Department: _____

Supervisor: _____

Details of Incident or Exposure:

_____

_____

_____

_____

Has employee been seen by primary physician or at a clinic or hospital? Yes _____No_____

If so, give Date of visit_____

What were the physicians' recommendations to employee?

_____ Self monitor and continue to report to work

_____ Self-isolation or self-quarantine at home

_____ Hospitalizations, if any

Signature of Employee : _____ Date: _____