Sun Health
EMPLOYEE SERVICES

COVID-19 Employee Call-Off Questionnaire

Employee calling off: _____

Date/Time of call-off: _____

Position/Title: _____

Shift calling off: Day(s): _____
Shift Time(s): _____

Reason for call off: _____

_____

Are you calling off R/T ANY of these symptoms? ☐ **N/A**

- ☐ **Temperature of 100.4 F or greater**
- ☐ **Cough**
- ☐ **Sore throat**
- ☐ **Sneezing**
- ☐ **Congestion**
- ☐ **Shortness of breath**
- ☐ **Runny Nose**
- ☐ **Muscle/Body Aches**
- ☐ **Tightness of chest**
- ☐ **Nausea/vomiting**
- ☐ **Loss of smell or taste**
- ☐ **Diarrhea**

If experiencing ANY of these symptoms, does the employee plan to get tested for COVID-19 outside of the community? ☐ **Yes** ☐ **No**

If yes, when? _____ **If yes, where?** _____

If no, are you calling off because a family member or someone who lives with you is exhibiting any of the symptoms listed above?

If yes, have they been tested? Date of test: _____

Do they plan to get tested? ☐ **Yes** ☐ **No** **When?** _____

Previous (3) days' work attendance & assigned areas:

_____

_____

Employee Action Plan:

_____

_____

Supervisor Action Plan:

Informed team member of PTO / PST Policy: ☐ **Yes** ☐ **No** **Date:** _____

_____

_____

Notification to HR- who and when: _____