STOP COVID-19

Please complete the following questions before beginning your work today.

Name: _____

Date: _____ Time: _____

Do you have any of the following:

Yes ☐
No ☐

Fever

Yes ☐
No ☐

Cough

Yes ☐
No ☐

Shortness of breath

Yes ☐
No ☐

Sore throat

Yes ☐
No ☐

Runny nose

Yes ☐
No ☐

Feeling unwell

Yes ☐
No ☐ Have you been in close contact with someone who is sick or has confirmed COVID-19 in the past 14 days?

Yes ☐
No ☐ Have you returned from travel outside Canada in the past 14 days?

If you answered YES to any of these questions, go home & self-isolate right away. Call Telehealth or your health care provider, to find out if you need a test.