COVID-19 EMPLOYEE SCREENING INVESTIGATION FORM

1. This form must be completed for each COVID-19 case and e-mailed to SJC Risk Management at sjcriskmgmt@sjgov.org within twenty-four (24) hours of knowledge. (Do not interview confirmed COVID-19 cases face-to-face.)
2. Departments are to comply with AB 685/Cal OSHA §3205 notification requirements within one (1) business day of knowledge of positive COVID-19 case.
3. If the employee is alleging illness is work-related, a *DWC-1 Workers' Compensation* form must be offered to the employee within one (1) business day of the knowledge of the illness.
4. For work-related hospitalizations notify SJC Risk Management directly during regular business hours. After hours complete and fax the *Cal OSHA After-Hours Reporting* form directly to Cal OSHA at (209) 545-7313 or e-mail to doshmod.dir.ca.gov and sjcriskmgmt@sjgov.org.

SECTION 1: EMPLOYEE INFORMATION:

First Name:		Last Name:		Employee ID Number:	
Employee's Work Email:		Employee's Phone Number:			
Division/Unit:		Primary Work Location:			
If work related, work location at time of exposure:					
Job Classification:		Bargaining Unit:	Select from list below:		
If non-employee, explain the reason individual was on County worksite:					
Direct Supervisor's Name:		Supervisor's Contact Number:			

SECTION 2: COVID-19 TEST INFORMATION:

Did the employee self-disclose their positive test results? ☐ YES ☐ NO		Test Date:	
Test Results: ☐ Positive ☐ Negative ☐ Inconclusive		Date Department Notified of Test Results:	
What prompted you to take test? ☐ Symptomatic ☐ Close Contact ☐ Outbreak ☐ Other:			
Did the employee present proof of being fully vaccinated? ☐ YES ☐ NO			
Identify source of potential exposure (e.g., work, home, co-worker or family member, travel):			
If employee has not tested, did you offer COVID-19 test information? ☐ YES ☐ NO			

SECTION 3: POTENTIAL EXPOSURE INFORMATION

Date Symptoms Began:		A "close contact" COVID-19 exposure is defined as someone who was within 6 feet of an infected person (laboratory-confirmed or a clinically compatible illness) for a cumulative total of 15 minutes or more over a 24-hour period (for example, three individual 5- minute exposures for a total of 15 minutes). An infected person can spread SARS-CoV-2 starting from 2 days before they have any symptoms (or, for asymptomatic patients, 2 days before the positive specimen collection date), until they meet criteria for discontinuing home isolation.
Date Last Worked at County Worksite:		
Date Last Worked at Home (telework):		
Did you have close contact as defined by CDC, two days prior to experiencing symptoms or receiving a positive test results (if both, whichever occurred first) with anyone at work (e.g., co-workers, clients, vendors, or other County employees)? ☐ YES ☐ NO		

Did the employee work at a County facility within two (2) days prior to experiencing symptoms or COVID-19 positive test? **If yes, what location(s):**

Did the employee conduct home or site visits to business within two (2) days prior to experiencing symptoms or COVID-19 positive test? **If yes, what location(s):**

SECTION 4: INTERVIEWING SUPERVISOR/MANAGER			
Is this employee able to telework/or able to continue to telework during isolation? ☐ YES ☐ NO			
If telework is not an option, list reason(s):			
If the employee is unable to telework, what is the first day off work?			
What is the estimated return-to-work date following current local Public Health Isolation Order?			
Did you offer information on the Workers' Compensation Claim Process at time of screening? ☐ YES ☐ NO			
Is the employee filing a COVID-19 related Workers' Compensation Claim at this time? ☐ YES ☐ NO			
Is the "facility or operation" covered by the Aerosol Transmissible Diseases regulations, Section 5199? ☐ YES ☐ NO			
If YES, does the employee perform "services" covered by the Aerosol Transmissible Diseases regulations, Section 5199? ☐ YES ☐ NO			
What were workplace conditions that could have contributed to the risk of COVID-19 exposure?			
What could be done to reduce exposure to COVID -19?			

SECTION 5: DEPARTMENT NOTIFICATION REQUIREMENTS		
AB 685/Cal OSHA §3205 – ***Department Notification*** *of "Potential Exposure" Requirement* in a worksite that may have been exposed to COVID-19.	Date Issued:	
AB 685/Cal OSHA §3205 – ***Employee Notification*** *of "Close Contact" to confirmed COVID-19 case.*	Date Issued:	
FMLA/CFRA Information: Departments are to follow standard leave of absence protocols when an employee is off work for medically related reasons. General guidelines recommend that if an employee is off work for three (3) days or more – send out appropriate FMLA/CFRA paperwork within 5 business days. Departments are to determine FMLA/CFRA eligibility as standard. Serious health conditions such as pneumonia and hospitalizations are triggers for FMLA/CFRA designation to be applied, if the employee is eligible.		
State Disability Information: An employee positive for COVID-19 or unable to work/telework for potential exposure must be provided information regarding California State Unemployment Insurance and Disability Program Information.		

PREPARED BY:			
Interviewing Manager/Supervisor Signature:		**Date Prepared:**	
Contact Number:			

FOR SJC HUMAN RESOURCES DIVISION USE ONLY					
Date Form Received:		WC Claim Received:		WC Claim Status:	
COVID-19 Diagnosis or exposure on County worksite: ☐ YES ☐ NO			Employee is Covered under ATD: ☐ YES ☐ NO		
Employee is eligible for Cal OSHA 3205 protected leave: ☐ YES ☐ NO			If Yes, From: _____ To: _____		
If NO, list reason of denial:					
Date Department Notified of Cal OSHA 3205 approval:					
Authorized Signature:			**Date:**		

SECTION 6: CLOSE CONTACT SCREENING

Instructions: This section must be completed for each employee identified as a close contact with the COVID-19 case. Every effort should be made to interview the COVID-19 case and any employee identified as a close contact by telephone or video conference instead of in-person.

Departments are responsible for reviewing and following federal, state, local public health guidance, Cal OSHA and orders on COVID-19.

COVID-19 Testing: Testing must be made available to any workplace close contacts, *regardless of vaccination status.*

To view current isolation/quarantine guidance or for a list of vaccine and testing locations information visit SJREADY.org or the Human Resources COVID-19 Information page at https://www.sjgov.org/covid19/employees.

POTENTIAL EXPOSURE CASE:

First Name:		Last Name:		Employee ID Number:	
Employee Email Address:		Employee's Phone Number:			
Division/Unit:		Primary Work Location:			
Work location at time of exposure:		Date of Exposure:			
Job Classification:		Bargaining Unit:	Select from list below:		

Did the employee present proof of being fully vaccinated? ☐ YES ☐ NO

Is this employee able to telework/or able to continue to telework during quarantine period? ☐ YES ☐ NO

If telework is not an option, list reasons (s):

If the employee is unable to work/telework, what is the first day off work based on the employee work schedule?

What is the estimated return-to- work date following current quarantine regulations/guidance?

Did you offer information on the Workers' Compensation Claim Process at time of screening? ☐ YES ☐ NO

Is the employee filing a COVID-19 related Workers' Compensation Claim at this time? ☐ YES ☐ NO

Is the "facility or operation" covered by the ATD regulations, section 5199? ☐ YES ☐ NO

If YES, are the "services" performed by the employee covered by ATD regulations, Section 5199? ☐ YES ☐ NO

PREPARED BY:

Manager/Supervisor Signature:		**Contact Number:**		**Date:**	

FOR SJC HUMAN RESOURCES DIVISION USE ONLY

Date Form Received:		WC Claim Received:		WC Claim Status:	
COVID-19 Diagnosis or exposure on County worksite: ☐ YES ☐ NO				Employee is Covered under ATD: ☐ YES ☐ NO	
Employee is eligible for Cal OSHA 3205 protected leave? ☐ YES ☐ NO				If Yes, From: _____ To: _____	
If NO, list reason of denial:				Date Department Notified of Status:	
Authorized Signature:				**Date:**	