

EMPLOYEE'S STATEMENT OF INCIDENT-COVID-19 EXPOSURE FORM

To be completed by injured employee and must answer all questions.

(Use another sheet if more space is needed.)

Name:	Phone Number – Home/Cell:
Job Title:	Phone Number – Work:
Department:	Supervisor:
Address:	
Exposure Incident	
Your Exposure Incident is: Known-Work Related Known-Alternate Source Unknown	
Date of Exposure Incident:	Location of Exposure Incident:
You notified your employer of COVID-19 exposure on: Date: / / Time: am pm	You reported the COVID-19 exposure to: Name: Title:
Provide details of exposure:	
The exposure was witnessed by:	
You tested positive for COVID-19: Yes No	You received your test results on: Date: / /
Work Status	
You missed work due to your exposure: Yes No If "Yes", answer the additional questions below.	
Your first day of missed time at work was: Date: / /	How were you paid for the missed work?
Your doctor currently has you off work until: Date: / /	You returned to work on: Date: / / OR Not yet returned
Prevention Measures	
You were wearing the employer recommended PPE at time of exposure: Yes No If No, describe any PPE that you were wearing:	
Additional COVID-19 Precautions in place at time of exposure: <i>(select all that apply)</i> Social Distancing (6ft) Face Coverings Employee Health Screen Physical Barrier Increased Cleaning/Sanitization Other, <i>please describe</i> :	
You live with or have been in close contact with someone outside of work that has been diagnosed with or is suspected of having COVID-19. Yes No If "Yes", describe the details of their exposure	
Your suggestion on how to prevent a similar future exposure incident:	

Employee's Signature:**Date:*****I have read the above statement and it is true and complete to the best of my knowledge.***