New Jersey Department of Military and Veterans Affairs
Screening Questionnaire for COVID-19

LAST NAME: _____ **DATE: _____**

FIRST NAME: _____ **SUPERVISOR:_____**

DEPARTMENT/UNIT: _____ **SUPERVISOR PHONE:_____**

While the Department cannot mandate disclosure, we strongly encourage voluntary disclosure to your immediate supervisor and the human resources department. Voluntary disclosure is a courtesy to your colleagues and will allow the Department to address exposure before it becomes a larger problem.

1.	Have you had, in the last 14 days, or are currently experiencing any of the symptoms listed below?		
	• Fever > 38°C or 100.4°F or subjective fever	**Yes**	**No**
	• Cough	**Yes**	**No**
	• Shortness of breath/breathing difficulties	**Yes**	**No**
	• Other symptoms such as muscle aches, fatigue, headache, sore throat, runny nose, diarrhea.	**Yes**	**No**
	If yes to any above, were you evaluated or treated by a physician?	**Yes**	**No**
2.	Have you traveled outside of the United States within the last 14 days?	**Yes**	**No**
3.	Have you had close contact (face-to-face contact within 2 meters/6 feet) with someone who is ill with fever, cough, and/or respiratory difficulties, or who has traveled internationally within 14 days prior to their illness onset?	**Yes**	**No**
4.	Have you been in contact in the last 14 days with someone who is being investigated or confirmed to be positive for COVID-19?	**Yes**	**No**

By signing below, I acknowledge that I have filled out this form voluntarily and have a full understanding of the information contained therein. I also agree that all the information provided is accurate to the best of my knowledge.

_____

SIGNATURE