DAILY HEALTH QUESTIONNAIRE

Employee name : _____
Department: _____
Date:_____

Please complete this questionnaire daily to ensure your presence at work is safe

1. Do you currently or have you had the following symptoms recently??

- Fever (over 38oC) ☐ Yes ☐ No
- Cough ☐ Yes ☐ No
- Respiratory difficulties ☐ Yes ☐ No
- Loss of smell ☐ Yes ☐ No
- Extreme fatigue ☐ Yes ☐ No

2. Have you been in contact with a person with the above symptoms or who have recently received a positive test for COVID-19?

- Yes ☐
- No ☐

For your own health and the safety of his co-workers, if you answered YES to any of the questions, you must immediately leave **the premises** and notify your supervisor or a person from Human Resources. This person will give you the information and the procedure to follow. You will need to return to your home and call 1-877-644-4545 for more COVID-19-specific information.

I am committed to taking the necessary steps to protect my health, safety and those of my co-workers.

Name in molded letter _____

Signature _____ Date _____