**Contact Tracing in the Workplace Form**

In light of your COVID-19 diagnosis or positive test on **[insert date]**, **[insert employer's name]** requests that you disclose where you have worked or conducted business and with whom you had close contact, so that we can advise staff members and other work-related individuals of their potential exposure to the virus. They will only be provided with general information, and you will remain anonymous.

***Please provide information for the 14 days prior to your diagnosis/positive test.***

Regular work location: **[insert employee's regular work location]**

Provide the date for each day you worked there (starting with the date 14 days prior to your diagnosis/positive test):

Sunday \_\_\_\_\_\_\_\_\_             Sunday \_\_\_\_\_\_\_\_\_              Sunday \_\_\_\_\_\_\_\_\_  
Monday \_\_\_\_\_\_\_\_\_            Monday \_\_\_\_\_\_\_\_\_              Monday \_\_\_\_\_\_\_\_\_  
Tuesday \_\_\_\_\_\_\_\_\_           Tuesday \_\_\_\_\_\_\_\_\_             Tuesday \_\_\_\_\_\_\_\_\_  
Wednesday \_\_\_\_\_\_\_\_\_      Wednesday \_\_\_\_\_\_\_\_\_        Wednesday \_\_\_\_\_\_\_\_\_  
Thursday \_\_\_\_\_\_\_\_\_          Thursday \_\_\_\_\_\_\_\_\_            Thursday \_\_\_\_\_\_\_\_\_  
Friday \_\_\_\_\_\_\_\_\_               Friday\_\_\_\_\_\_\_\_\_                  Friday \_\_\_\_\_\_\_\_\_  
Saturday \_\_\_\_\_\_\_\_\_           Saturday \_\_\_\_\_\_\_\_\_            Saturday \_\_\_\_\_\_\_\_\_

Identify any employees or other individuals with whom you had close contact (i.e., you were within approximately six feet for a prolonged period):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you visited any other **[insert employer's name]** facility in the 14 days prior to your diagnosis/positive test?

* Yes
* No

If yes, list the other location(s), date(s) of your visit and any employees or other individuals you had close contact with:

Location                                                  Date                   Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you traveled to non-**[insert employer's name]** locations for business purposes in the 14 days prior to your diagnosis/positive test?

* Yes
* No

If yes, list the company name, location, date(s) of your visit and any individuals with whom you had close contact:

Company/location                                   Date                   Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that the above statements are true and correct.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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