WALKER CONSTRUCTION

Employee Health Questionnaire

Date:_____ Personnel evaluating staff:_____

Questionnaire
1. Have you been confirmed positive for COVID-19?
2. Are you currently experiencing, or recently experienced, any acute respiratory illness symptoms such as fever, cough, or shortness of breath?
3. Have you been in close contact with any persons who has been confirmed positive for COVID-19?
4. Have you been in close contact with any persons who are exhibiting acute respiratory illness symptoms?

Employee Name	*Jobsite*	*Q1*	*Q2*	*Q3*	*Q4*	*Temp*	*Comments*

Staff gathering information Signature: _____

By signing this form you certify that the above information is true and correct and that any dishonest answers may have serious health implications. Thank you for helping us keep our community safe!