# Contact Tracing Form

Due to your COVID-19 diagnosis or positive test on **[insert date]**, [**insert Company name**} requires that you disclose where you have worked or conducted business and identify which individuals whom you have come into close contact. We ask this of you avoid any other potential exposures and identify and inform these individuals of their potential exposure to the virus. The Company will safeguard information private and only provide such individuals whom you have identified with general information.

Close contact is defined as being within six feet for a cumulative total of 15 minutes or more over a 24-hour period.

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

Regular worksite name: **[indicate employee's regular work site]**

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

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Sunday  | Monday  | Tuesday | Wednesday | Thursday | Friday | Saturday |
| Date |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |

Identify any individuals (including any employees and third parties) whom you had close contact:

|  |  |
| --- | --- |
| Date | Contact Name |
|  |  |
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Have you visited any other **[insert employer's name] worksite,** facility, location or conducted any business other than at your regular worksite or non-workplace location in the 14 days prior to your diagnosis/positive test?

* Yes
* No

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

|  |  |  |
| --- | --- | --- |
| Location Name | Date | Contact Name |
|  |  |  |
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If you traveled to non-**[insert employer's name]**locations for business purposes in the 14 days prior to your diagnosis/positive test list the company name, location, date(s) of your visit and any individuals (including third parties) with whom you had close contact:

|  |  |  |
| --- | --- | --- |
| Location Name | Date | Contact Name |
|  |  |  |
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|  |  |  |

I certify that the above statements are true and correct.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_