NEVADA HEALTH RESPONSE

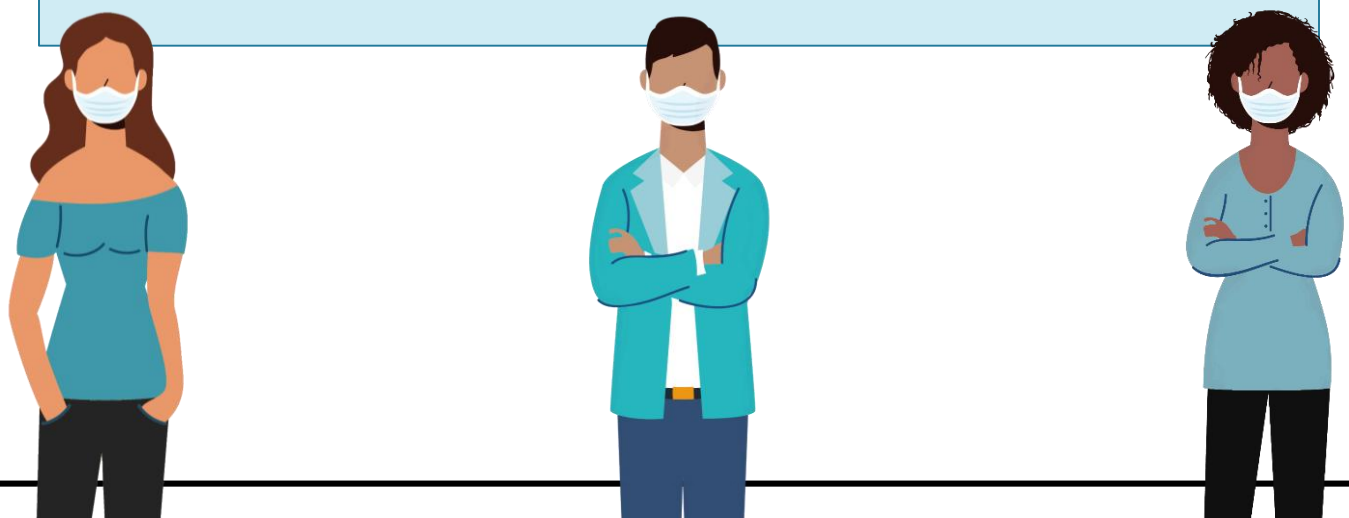
COVID-19 SCREENING FOR EMPLOYEES

A SCREENING IS CONDUCTED EACH TIME AN EMPLOYEE ENTERS THIS FACILITY

If an employee answers "YES" to any of the following questions, they should be advised to go home, stay away from other people, contact their supervisor to discuss options for telework or leave, and contact their primary care provider or local health authority for further instructions

Please answer "YES" or "NO" to each question:

1. **Have you experienced any of the following symptoms in the past 48 hours?:**
   - Fever or chills
   - Cough
   - Shortness of breath or difficulty breathing
   - Muscle or body aches
   - Headache
   - New loss of taste or smell
   - Sore throat
   - Congestion or runny nose
   - Nausea or vomiting
   - Diarrhea
2. **Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have a confirmed case of COVID-19 or with anyone who has any symptoms consistent with COVID-19?**
3. **Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?**
4. **Are you currently waiting on the results of a COVID-19 test?**



COVID-19 SCREENING FOR EMPLOYEES

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If an employee answers "YES" to any of the following questions, they should be advised to go home, stay away from other people, contact their supervisor to discuss options for telework or leave, and contact their primary care provider or local health authority for further instructions

DATE	TIME	NAME	Have you experienced symptoms of COVID-19 in the past 48 hours?*	In the past 14 days, have you had contact with anyone confirmed to have COVID-19 or who has symptoms of COVID-19?	Are you isolating or quarantining because you may have been exposed or are you worried you may be sick with COVID-19?	Are you currently waiting on the results of a COVID-19 test?
			YES / NO	YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO	YES / NO
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			YES / NO	YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO	YES / NO
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			YES / NO	YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO	YES / NO

* Symptoms of COVID-19 include: fever or chills, cough, shortness of breath or difficulty breathing, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea

NEVADA HEALTH RESPONSE

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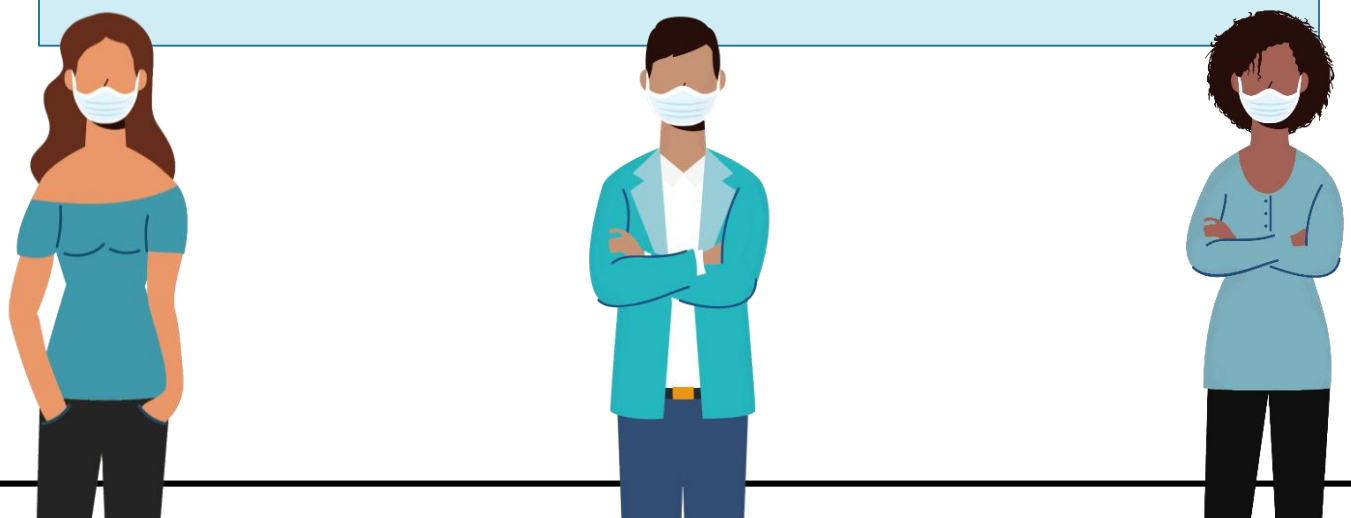
COVID-19 SCREENING FOR VISITORS

A SCREENING IS CONDUCTED EACH TIME A VISITOR ENTERS THIS FACILITY

If a visitor answers "YES" to any of the following questions, they should be advised to go home, stay away from other people, and contact their primary care provider or local health authority for further instructions.

Please answer "YES" or "NO" to each question:

1. **Have you experienced any of the following symptoms in the past 48 hours?:**
   - Fever or chills
   - Cough
   - Shortness of breath or difficulty breathing
   - Muscle or body aches
   - Headache
   - New loss of taste or smell
   - Sore throat
   - Congestion or runny nose
   - Nausea or vomiting
   - Diarrhea
2. **Within the past 14 days, have you been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have a confirmed case of COVID-19 or with anyone who has any symptoms consistent with COVID-19?**
3. **Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?**
4. **Are you currently waiting on the results of a COVID-19 test?**



COVID-19 SCREENING FOR VISITORS

A SCREENING IS CONDUCTED EACH TIME A VISITOR ENTERS THIS FACILITY

If a visitor answers "YES" to any of the following questions, they should be advised to go home, stay away from other people, and contact their primary care provider or local health authority for further instructions.

DATE	TIME	NAME	Have you experienced symptoms of COVID-19 in the past 48 hours?*	In the past 14 days, have you had contact with anyone confirmed to have COVID-19 or who has symptoms of COVID-19?	Are you isolating or quarantining because you may have been exposed or are you worried you may be sick with COVID-19?	Are you currently waiting on the results of a COVID-19 test?
			YES / NO	YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO	YES / NO
			YES / NO	YES / NO	YES / NO	YES / NO
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			YE S / NO	YE S / NO	YE S / NO	YE S / NO
			YES / NO	YES / NO	YES / NO	YES / NO
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* Symptoms of COVID-19 include: fever or chills, cough, shortness of breath or difficulty breathing, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, diarrhea

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