COVID 19 Employee Wellness Checklist
Return to Work

Print Name: ________________________________

Location: ________________________________

Wellsite Company name: ________________________________

Within the past 24 hours have you:

had a persistent dry cough? _______________

experienced shortness of breath? _______________

had a fever? _______________

taken any cold/flu or fever reducing medication? _______________

Within the past 14 days have you been in close contact with any household member or other person who has tested positive for COVID-19, was suspected of having COVID-19, or had symptoms associated with COVID-19 (e.g. fever, cough, difficulty breathing)? ("Close contact" means being within six Feet for more than a few minutes) _______________

I have answered all questions honestly and will continue to practice social distancing (6 foot spacing), and good hygiene including handwashing/sanitizing.

Employee: ____________________________________ Date: ____________

Location Manager: _____________________________ Date: ____________

This document will be completed by all employees prior to returning from days off or vacation. The document will be reviewed by the location manager or HSE Advisor before the employee can travel to return to work.

Symptom Wellness checks will continue to be conducted daily at the wellsite.