



Today's Date: __/__/

I certify that the information provided is correct to the best of my knowledge.

Employee/Visitor Name: (Please Print) _____

Employee/Visitor Name: (signature) _____

Judiciary Building: circle one (MJC) (COA) (APOD) (JIS) (other)_____

HEALTH SCREENING QUESTIONNAIRE

For infection control purposes, please complete the below questions:	
<p>1. Have you had any of the following symptoms in the last seven (7) days:</p> <ul style="list-style-type: none"> • Cough (either new, or different than your usual cough), shortness of breath, or difficulty breathing? • Fever (either subjective, or measured) or chills? • Sore throat, unusual muscle pain, or unusual headache? • New loss of taste or smell? • Nausea, vomiting, diarrhea, or any other flu-like symptoms? • <i>Current body temperature is _____ f (SPO/ screener will complete)</i> 	<input type="checkbox"/> *Yes <input type="checkbox"/> No
<p>2. Have you had a positive test for COVID-19 infection within ten (10) days with symptoms?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. Have you received both shots of the Pfizer or Moderna vaccine? If yes, skip the next question.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. If you have not received both shots of the Pfizer or Moderna vaccine, have you been in close, prolonged contact (less than 6 feet for more than 15 minutes within the last week) with someone with a fever, cough, shortness of breath, nausea, vomiting, diarrhea, flu-like symptoms, or a diagnosis of COVID-19?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No



Individuals who answer YES to -questions 1, 2 or 4 on the Health Screening Questionnaire** OR have a temperature of 100.4°F [38°C] OR refuse to participate in the screening process **must** be denied access to the facility.

Those who are denied access should immediately contact their direct supervisor, HR-Employee Relations at (410) 260-1732 or ER@mdcourts.gov, and their doctor for further assistance.

Access Determination: _____ Approved _____ Denied

SPO/ Name of screener: _____ Date: _____ Time

* If yes, you may need medical clearance before returning to work

** Unless proper medical documentation is on file with HR to authorize an exception.