CCT DAILY HEALTH ASSESSMENT

NAME _____________________________________

Following the mandates of EMERGENCY ORDER 2020-01, CCT will be implementing a daily health screenings for all employees who are not working from their residence.

PLEASE ANSWER THE FOLLOWING QUESTIONS. IF YOU ANSWER YES TO ANY QUESTION, PLEASE CONTACT JILL OR RYAN IMMEDIATELY.

Have you been in “Close Contact” in the last 14 days with someone with a diagnosis of COVID-19?
Yes/No If YES, please provide date of contact ____________________________________________

Have you traveled in the last 14 days? (travel to other areas of state or to other states)
Yes/No If YES, please explain ___________________________________________________________

Please indicated if you have any of the following symptoms by providing the date the symptoms began

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<thead>
<tr>
<th>SYMPTOMS</th>
<th>Cough</th>
<th>Shortness of Breath</th>
<th>Sore Throat</th>
<th>Diarrhea</th>
<th>Loss of Taste/Smell</th>
<th>Fatigue</th>
<th>Headache or Body Aches</th>
<th>Nausea or Vomiting</th>
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</thead>
<tbody>
<tr>
<td>Date of onset of symptoms</td>
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Current Body Temperature ____________ (if a non-contract thermometer is not available please take your temperature at home are self-report)

If you answered yes to any questions above; please contact your manager/supervisor immediately

EMPLOYEE SIGNATURE ______________________________________ DATE ___________________

MANAGEMENT REVIEW:

REVIEWED BY: ______________________________________ DATE ___________________

ACTION TAKEN ______________________________________________________________