**COVID-19 EXPOSURE AND MEDICAL QUESTIONNAIRE**

**(TO BE COMPLETED BY EMPLOYER)**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Employee Details** | | | | | | | | | | |
| Full Name & Surname | | |  | | | | | | | |
| Employee Contact Number | | |  | | | | | | | |
| ID Number/Passport Number | | |  | | | | | | | |
| Email Address | | |  | | | | | | | |
| Occupation | | |  | | | | | | | |
| **Employer Details** | | | | | | | | | | |
| Name of Employer | | |  | | | | | | | |
| Industry / Sector | | |  | | | | | | | |
| Province | | |  | | | | | | | |
| Contact Person Name & Surname | | |  | | | | | | | |
| Contact Person Details | | | Email |  | Phone no |  | | | | |
| **Travel History** | | | | | | | | | | |
| Has the employee traveled to any high risk areas / countries | | | | | | | | Yes | | No |
| **If Yes** | | | | | | | | | | |
| 1. | Area travelled |  | | | | | | | | |
| 2. | Date travelled |  | | | | | | | | |
| 3. | Length of stay |  | | | | | | | | |
| 4 | Reason for travel |  | | | | | | | | |
| **If No, has the employee been exposed to a confirmed occupationally-exposed case in the workplace Yes/ No, If Yes** | | | | | | | | | | |
| 1. | Date of contact |  | | | | | | | | |
| 2. | Contact reported | | | | | | | Yes | | No |
| 3. | Period of exposure |  | | | | | | | | |
| 4. | Cases on quarantine in area of work |  | | | | | | | | |
| 5. | Total confirmed cases in the workplace |  | | | | | | | | |
| **Medical History** | | | | | | | | | | |
|  | | | | | | | | | | |
| 1. | Does the employee suffer from any pre-existing medical conditions? | | | | | | | Yes | | No |
| 2. | Has the employee been diagnosed with any other occupational disease? | | | | | | | Yes | | No |
| **If any of the above questions were answered yes, complete all the boxes below**  **Medical Condition:** | | | | | | | | | | |
| 3. | Pregnant? (Trimester:…………………………………) | | | | | | | Yes | | No |
| 4. | Post Partum (After given birth) (<6weeks) | | | | | | | Yes | | No |
| 5. | Cardiovascular disease including hypertension | | | | | | | Yes | | No |
| 6. | Immunodeficiency, including HIV | | | | | | | Yes | | No |
| 7. | Diabetes | | | | | | | Yes | | No |
| 8. | Renal Disease | | | | | | | Yes | | No |
| 9. | Liver Disease | | | | | | | Yes | | No |
| 10. | Chronic lung disease | | | | | | | Yes | | No |
| 11. | Chronic neurological or neuromuscular disease | | | | | | | Yes | | No |
| 12. | Malignancy (Growth etc.) | | | | | | | Yes | | No |
| 13. | Other(s), please specify: | | | | | | | | | |
| **Medical Condition** | | | | | | | | | | |
|  | Condition | | | | Year of Diagnosis | | On Treatment | | | |
| 1. | Pre-existing Condition: | | | |  | | Yes | | No | |
| 2. | Occupational Diseases | | | |  | | Yes | | No | |

Name & Surname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OMP Signature/Stamp\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_