**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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_