



COVID-19 Employee Self-Identification Form

Employee Name: _____ Date: _____

Employee No.: _____ Department: _____

Job Title: _____ Supervisor Name: _____

In order to comply with the Families First Coronavirus Response Act and protect our workforce during the COVID-19 outbreak, we are asking employees to self-identify if they fall into one of the following categories. This self-identification form will assist the County in determining which pay and leave scenario applies to your circumstances. Please check if any of the following apply to you. You may select more than one. **If you select numbers 1-6, you must also complete the FFCRA Paid Sick Leave Request Form.**

- _____ [1] I am subject to a Federal, State, or local quarantine or isolation order related to COVID-19;
- _____ [2] I have been advised by a health care provider to self-quarantine related to COVID-19;
- _____ [3] I am experiencing COVID-19 symptoms and am seeking a medical diagnosis;
- _____ [4] I am caring for an individual subject to an order described in (1) or self-quarantine as described in (2);
- _____ [5] I am caring for my child (biological, adopted, foster, stepchild, a legal ward, or a child for whom you are standing in loco parentis) whose school or place of care is closed (or child care provider is unavailable) due to COVID-19 related reasons; or
- _____ [6] I am experiencing any other substantially-similar condition specified by the U.S. Department of Health and Human Services.
- _____ [7] I am experiencing COVID-19-like symptoms and am not seeking a medical diagnosis from a health care provider.
- _____ [8] I have been in close contact (less than 6 feet) with a family member, coworker or other individual who is exhibiting COVID-19-like symptoms or is in quarantine.
- _____ [9] I, a family or household member, or a person for whom I am caring, is considered high risk because of age, health conditions, or other criteria as stated by the CDC, and has not been advised by a health care provider to self-quarantine, and I choose not to report to work in person and have the ability to work remotely all or part of the time.
- _____ [10] I, a family or household member, or a person for whom I am caring, is considered high risk because of age, health conditions, or other criteria as stated by the CDC, and has not been advised by a health care provider to self-quarantine, and I choose not to report to work in person and do not have the ability to work remotely all or part of the time.
- _____ Personal choice to travel to locations identified as higher risk by CDC, CDPHE, or other related authorities.

La Plata County will keep all employee medical information as confidential as possible. Please do not share detailed health information with your supervisor or coworkers. Information contained in this form will be used solely for administrative and operational purposes.

Employee Signature

Date

Supervisor Signature

Date