



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, complete the below questions:	Response:
1. Have you received both shots of the Pfizer or Moderna vaccine? If yes, no further action is needed. If not, proceed to the additional questions.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you had any of the following symptoms in the last seven (7) days: <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
3. Have you had a positive test for COVID-19 infection within ten (10) days with symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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 adiagnosis of COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No



Individuals who answer **YES** to questions 2, 3, 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, or 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.