BUFFALO STATE
The State University of New York

Weekly COVID-19 Screening Questionnaire

Employee Name	
Department/Office	
Date	Week beginning:

In order to help prevent the spread of the coronavirus and reduce the potential risk of exposure, all employees planning to report to the worksite should complete this questionnaire daily two hours *before* reporting to work.

This form must be filled in daily and submitted to your supervisor weekly.

Please choose either YES or NO for each of questions 1 through 5 by placing your ***initials*** in the appropriate boxes each day *before* you report to work.

If you answer **YES** to any of screening questions 1 through 4:

- **Do not report to work.**
- Notify your supervisor.
- Contact the Human Resource Management Department for guidance at 716-878-4822.

		SUN	MON	TUES	WED	THURS	FRI	SAT
1. I have a fever above 100 degrees Fahrenheit.	YES							
	NO							
2. I have had COVID-19 symptoms within the past 14 days: • Cough • Shortness of breath or difficulty breathing • Fever • Chills • Muscle pain • Sore throat • New loss of taste or smell	YES							
	NO							
3. I have had a positive COVID-19 test within the past 14 days.	YES							
	NO							
4. I have had close contact with confirmed or suspected COVID-19 cases within the past 14 days.	YES							
	NO							
5. I have a mask in my possession available for immediate use.	YES							
	NO							

Signature: _____Date:_____