COVID-19 Exposure Form

First and Last Name:

____

Current Residential Address:

____

Telephone Number:

____

E-mail Address:

____

Are you a member of a union? □ Yes □ No

If yes, name of union and local number: ____

Job Title:

____

Employer:

____

Regularly assigned Work Location - Address:

____

On the date of: ___________________________________**, I was in the immediate physical presence of and**

MM/DD/YYYY

exposed to:

____

First and last name (if known) of person exhibiting COVID-19 symptoms

who was exhibiting specific COVID-19 symptoms of: □ coughing □ wheezing □ difficulty breathing

□ other: ____,

while working at: □ my regularly assigned work location (listed above)

□ other location: ____.

Upon information and belief, above person had tested positive for COVID-19. I know this person to be true because:

____

The work-related relationship of the above person is: □ customer □ client □ co-worker □ tenant

□ other: ____

This described exposure occurred at the direction of:

____

First and Last Name of person (supervisor, etc.)

My regular duty(ies) being performed at the time of exposure were:

____

____

Signed: ____ **Date:** ______________________________