BANK OF SOMEWHERE

COVID-19 EMPLOYEE PRESCREENING QUESTIONNAIRE

INSTRUCTIONS

**Directions:**

These questionnaires are to be completed and signed by the employee or dictated to an approved Human Resources Specialist [insert title, name etc. as applicable] at **[determine an interval: i.e.- once a week, when returning to work from a vacation or absence, etc]**.

It is the Policy of **BANK OF SOMEWHERE** to retain Employee COVID-19 Questionnaires for a period of **[1 week, 14 day, 1 month]** after completion. They are to be stored in/at **[designate approved location]** separately from an employee’s file in accordance to the ADA’s requirements on medical information of employees. It is important to remember that if the Bank is an employer with a self-insured health plan, it has additional requirements under HIPAA that must be met to maintain compliance and confidentiality.

Upon the completion of the retention period, an approved Human Resources Specialist **[insert title, name, etc. as applicable]** will destroy the Questionnaire via the secured method of: **[Shredding, 3rd party shredding service, etc. as applicable to Bank current procedures]**. This is to include the scrubbing and permanent deletion of and any all electronic copies that may be in existence due to being submitted electronically, via fax, scanning, email or otherwise.

Upon destruction, **BANK OF SOMEWHERE** will document the routine destruction of these Questionnaires without disclosing any personal identifiable information.

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COVID-19 EMPLOYEE PRESCREENING QUESTIONNAIRE

**Directions:** Please complete accurately the following questionnaire to assist the **BANK OF SOMEWHERE** in preventing the spread of the COVID-19 virus and continue to ensure the safety of our employees, our customers and the general public. Please refer to the back of this form for applicable disclosures. We appreciate your understanding and cooperation during these times.

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| **COVID-19 Precautions** | **YES** | **NO** | **COMMENT** |
| 1. Have you traveled to any of these locations in the last 14 days?  * China * Iran * South Korea * Italy * Japan |  |  |  |
| 1. Have you traveled domestically in the United States to any of the following States in the last 14 days?  * New York * New Jersey * California * Washington State |  |  |  |
| 1. Have you had contact with anyone confirmed COVID-19 in the last 14 days? |  |  |  |
| 1. Have you had any of these symptoms in the last 14 days?  * Fever greater than 100.4° F * Difficulty breathing * Cough |  |  |  |
| 1. Are you currently experiencing a fever over 100.4° F, difficulty breathing, or cough? |  |  |  |
| **If you answered yes any of the questions, for the protection of BANK OF SOMWHERE personnel, the general public, and yourself, we would advise you to:**  [insert appropriate methods to contact bank personnel for phone call appointment; provide options to call center support, online banking, emailing, telebanking; provide options for ATMs with check cashing capabilities, relative fax numbers] | | | |

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| **Additional Comments:** |

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| **Employee Name and Position:** |
| **Employee Signature:** |
| **Date:** |

**Disclosures:**

***HIPPA and ADA Protections:*** *Generally, financial institutions do not fall under HIPAA’s defined “Covered Entities,” which would prohibit them from disclosing protected health information (PHI) unless permitted by HIPAA. An individual’s health status related to testing positive for COVID-19 is considered PHI. However,* ***BANK OF SOMEWHERE*** *for COVID-19 prescreening precautions will treat any information submitted on this form as if it were a Covered Entity and will keep answers confidential as well as will only disclose to public health authorities as applicable by law.*

***Employers with Self-Insured Health Plans***: *Self-insured employee health plans maintained by an employer are Covered Entities under HIPAA. PHI obtained cannot be disclosed unless permitted by HIPAA. See [Self-Insured Employee Health Plan Handbook or other applicable document provided by HIPAA] for additional guidance.*

***BANK OF SOMEWHERE*** *[****is/is not****] an employer with a self-insured health plan.*

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| **HR Bank Personnel Reviewer Name and Title:** |
| **HR Bank Personnel Reviewer Signature:** |
| **Date of Review:** |

***ADA Protections:*** *ADA requires employers who receive medical information in a confidential file separate from employee’s personnel file. The Center for Disease Control has encouraged employers to question employees regarding travel, exposure, or symptoms related to COVID-19. In compliance,* ***BANK OF SOMEWHERE*** *will ensure answers are kept confidential and if a positive case is identified, perform an investigation without disclosing any personally identifiable information. ADA confidentiality requirements do not prohibit disclosure to state, local or federal health departments as legally required.*

***Privacy Policy:*** *Refer to the* ***BANK OF SOMWHERE’s*** *Privacy Policy for additional guidance found here: [insert website].*