

**Specialized Service Provider and On-site activities**

**Daily Screening Document**

**SERVICE PROVIDER AND COMPANY NAME :**

**DATE\*:**

**BRIEFLY OUTLINE BELOW THE PURPOSE OF YOUR VISIT:**

**DOES YOUR COMPANY HAVE ESTABLISHED DAILY HEALTH SCREENS IN PLACE?**

**IF YES PLEASE PROVIDE SPECIFICS.**

**Other Questions:**

1. Please provide specific information on the travel plans to WSU for the service engineer.
2. Please provide specifics on travel by the service engineer within the last 14 days.
3. What is the company/home location for the service engineer?
4. What is the expected duration of time that the work will take?
5. Will the service engineer come and operate the work alone?
6. What will they bring with them to perform the work?
7. How will the testing equipment be verified clean before arrival?
8. Does the vendor require masks and gloves at all times?
9. Does the service engineer have permission to work alone in the room?
10. How does the service engineer discard materials that they will leave behind?
11. How will they transport their equipment into and out of the building?

Fields with asterisks (\*) are required.

**Contact phone number*\*:***

**Building(s) to access:**

**In the past 48 hours, or since your last visit to a University facility, have you experienced any of the following symptoms? (please check all that apply)**

[ ]  A new fever (100.4 F or higher) or a sense of having a fever?

[ ]  A new cough that you cannot attribute to another health condition?

[ ]  New shortness of breath that you cannot attribute to another health condition?

[ ]  A new sore throat that you cannot attribute to another health condition?

[ ]  New muscle aches that you cannot attribute to another health condition or that may have been caused by a specific activity, such as physical exercise?

[ ]  New respiratory symptoms, such as sore throat, runny nose/nasal congestion or sneezing, that you cannot attribute to another health condition?

[ ]  New chills or repeated shaking with chills that you cannot attribute to another health condition?

[ ] New loss of taste or smell that you cannot attribute to another health condition?

**Have you had close contact in the last 14 days with an individual diagnosed with COVID-19? *\****

[ ]  Yes

[ ]  No

**Have you traveled *via* airplane internationally or domestically in the last 14 days? *\****

[ ]  Yes

[ ]  No

**Have you had a COVID-19 test and are currently awaiting results? *\****

[ ]  Yes

[ ]  No