HEALTHCARE WORKER ASSESSMENT FORM FOR COVID-19

Name- **Current Job Title-**

Phone No.- **Address-**

	Please Tick	
	YES	**NO**
1. Symptoms (experienced within last 14 days)		
• Fever/Sweating/Chills		
• Sore Throat		
• Vomiting/Diarrhoea		
• Cough/Cold		
• Aches		
• Shortness of breath		
2. Recent Exposure (within last 14 days)		
• **Working/worked in a COVID situation**		
• **Possible close contact with a positive COVID person**		
• **Advised to restrict movement for 14 days**		
• **Advised to self-isolate for 14 days**		
3. Recent Travel (within last 14 days)		
• **Travelled from outside the Republic of Ireland in last 14 days**		
• **Relocation from another region within the Country**		

1. If you have ticked YES for any symptoms mentioned in Section 1. We would advise you to speak to your GP regarding the same and possibly self-isolate until advised otherwise.
2. If you have ticked YES for any segment in Section 2 and about start with an assignment with the agency, then we would request you to follow the HSE Guidelines and request COVID 19 testing and provide the result to the agency coordinator.
3. If you have travelled from outside the Republic of Ireland in past 14 days, we would advise you to restrict your movement initially. Testing is not necessary until developed symptoms. Please also stay informed regarding any new developments on https://www2.hse.ie/conditions/covid19/

If you require any assistance or have any queries regarding the form, please contact Hollilander Team at **012040921** or send and email to **adminireland@hollilander.com**

Healthcare Worker Signature: **Date:**