RESET

WorkSafeBC

COVID-19 Initial Screening Questionnaire

Worker Demographics

Worker's last name	First name	Middle initial	WorkSafeBC claim number
Birthdate (yyyy-mm-dd)	Occupation	Employer(s)	

Workplace Exposure

Were you advised by an individual in your workplace that you were exposed to COVID-19 while at work?

☐ Yes ☐ No

Are you aware of any other confirmed cases of COVID-19 at your workplace in the 14 days leading up to your illness?

☐ Yes ☐ No

Was an outbreak declared at your place of employment?

☐ Yes ☐ No

Please provide details about how and when you were exposed to COVID-19, and why your work placed you at risk for contracting COVID 19? (For example, were you in contact with a person at work who had a confirmed or probable diagnosis of COVID-19?)

Please describe your job duties.

Please describe your work environment. (e.g., indoors or outdoors, in close proximity to the public or coworkers, whether masks are required or you work from home).

COVID-19 Testing

Have you experienced any symptoms of COVID-19? ☐ Yes ☐ No	If yes, when did you first experience symptoms? (yyyy-mm-dd)

Describe your symptoms

Have you been tested for COVID-19?

☐ Yes ☐ No

Type of test ☐ PCR ☐ Rapid antigen test (work or home-based)	Date of test (yyyy-mm-dd)	Location of test

Test result ☐ Positive ☐ Negative	If available, please attach a copy of your COVID-19 test results by clicking the Attach button to submit with this document

COVID-19 Initial Screening Questionnaire

Worker's last name	First name	Middle initial	WorkSafeBC claim number

Reason for not being tested

Did you seek any medical treatment for your COVID-19 infection? If so, please provide the name of the hospital you attended and/or the name(s) of your physician (or specialist) / medical clinic(s) where you sought treatment

Time loss

Have you lost time from work or lost wages because of COVID-19?

☐ Yes ☐ No

Reason

☐ Positive COVID-19 test ☐ Quarantine/self-isolation as precaution

☐ COVID-19 symptoms ☐ Other (Please Explain)

Last day worked (yyyy-mm-dd)	First shift missed (yyyy-mm-dd)	Do you have more than 1 employer?
		☐ Yes ☐ No

Did you work a full shift on your last day worked?	If no, for the last day worked provide:		
☐ Yes ☐ No	Hours scheduled to work:	Hours worked:	Hours pay by employer:

Have you returned to work?	Return-to-Work date (yyyy-mm-dd)	Expected Return-to-Work date (yyyy-mm-dd)
☐ Yes ☐ No		

Have you seen a physician to authorize being off work beyond 10 days from the onset of symptoms?

☐ Yes ☐ No

Wage Information

Is your employer continuing to pay your salary?	Is the employment permanent or temporary?	Have you been with the employer less than 12 months?
☐ Yes ☐ No	☐ Permanent ☐ Temporary	☐ Yes ☐ No

Current base salary (hourly rate)	Check any that you receive in addition to the base salary?
$ / hour	☐ Overtime ☐ Shift differential ☐ Vacation pay ☐ Tips/gratuities ☐ Self-employed / subcontractor

Work schedule type

☐ Fixed hours ☐ Variable hours ☐ Rotating (provide rotation information below)

Which day(s) of the week is/are worked?

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Enter the number of hours of each day

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Please describe the on/off pattern for one shift rotation

On	Off	On	Off	On	Off	On	Off	On	Off	On	Off

COVID-19 Initial Screening Questionnaire

Worker's last name	First name	Middle initial	WorkSafeBC claim number

Other Potential Exposures

Did any of your household members or close friends who you see often develop symptoms of COVID 19 or test positive for COVID 19 before or after you were infected? ☐ Yes ☐ No	Please provide dates (yyyy-mm-dd)

Please describe any activities you participate in outside of work, such as sports, going to the gym or fitness centre, social, personal or religious gatherings, or attending places where you interact with other people.

In any of the activities you participate in outside of work, were you exposed to a person or people with confirmed or probable COVID-19 in the 14 days before you were diagnosed with COVID-19? ☐ Yes ☐ No	Please provide dates (yyyy-mm-dd)

Have you travelled prior to the onset of your symptoms? Where and when

Please provide any other information that you think may be relevant to your COVID-19 claim

☐ I declare all the information I have given on this questionnaire is true and correct.

☐ I understand the information is collected, used, and disclosed under the authority of the Workers Compensation Act and the Freedom of Information and Protection of Privacy Act.

Signature	Date of signature (yyyy-mm-dd)

How to submit your form

Online is the quickest and easiest method: Once you've completed this fillable form and added your electronic signature, visit **worksafebc.com/claims-uploader** to submit the electronic document to your claim file.

Alternatively, you can fax your form to 604.233.9777 (toll-free at 1.888.922.8807), or send by mail to:

WorkSafeBC, PO Box 4700 Stn Terminal, Vancouver BC V6B 1J1

For assistance in completing or submitting this form

Claims Call Centre, 604.231.8888 or toll-free at 1.888.967.5377, M–F, 8 a.m. to 6 p.m.

WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's freedom of information coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or call 604.279.8171.