

**WRC COVID-19 FORM FOR VENDOR/PROVIDER’s EMPLOYEE/STAFF**

***TO BE COMPLETED IN WORD FORMAT AND E-MAILED TO THE WESTSIDE REGIONAL CENTER DESIGNATED SIR EMAIL ADDRESS***

**Send the SIR and COVID 19 Form** [**SIR@westsiderc.org**](mailto:SIR@westsiderc.org)

**Your assistance is needed and appreciated. The Department of Developmental Services (DDS) has requested that vendors and Long term Care Providers (ICF DD- H/N/ CN) report any Employee/Staff who are symptomatic (fever, cough, shortness of breath) or have been tested for COVID-19.**

**Date Written:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Form Updated On: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Written by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vendor/Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vendor #\_\_\_\_\_\_\_\_\_\_\_\_\_**

**All FIELDS ARE REQUIRED UNLESS OTHERWISE INDICATED.**

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| --- | --- | --- | --- |
| **1. Date Reported To County Public Health:** | | **2. Which County Reported To:** | |
| **3. EMPLOYEE’S WORK SITE (Include the vendor’s name and the location where the employee works):** | | | |
| **4. Number of consumers/employees at employee’s worksite: #C \_\_\_\_\_ / #E \_\_\_\_\_** | | | |
| **5. Date Symptoms Noted:** | | **6. Isolation: 🞏 Y/ 🞏 N** | **7. If Yes, Date:** |
| **8. Tested: 🞏 Y / 🞏 N** | **9. If Yes, Date:** | **10. Test Results:** | **11. 🞏 Positive**  **🞏 Negative** |
| **12. Comments:** | | | |

3.23.20