

Facility ID#:

*HCW ID#:

Social Security #:

Secondary ID#:

HCW Name, Last:

First:

Middle:

Street Address:

City:

State:

Zip Code:

Home Phone: ()

Email Address:

*Gender: ☐ F ☐ M ☐ Other

*Date of Birth: / /

Born in U.S.? ☐ Yes ☐ No ☐ Unknown

Ethnicity: ☐ Hispanic or Latino
☐ Not Hispanic or Not Latino

Race: ☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White

Employment Information

Work Phone: ()

*Start Date: / /

*Work Status: ☐ Active ☐ Inactive ☐ No longer affiliated

*Type of employee: ☐ Full-time ☐ Part-time ☐ Contract employee ☐ Volunteer ☐ Other (specify) _____

*Work Location:

Department:

Supervisor:

*Occupation: Title:

If occupation is a physician, indicate clinical specialty (check one):

- | | |
|---|--|
| <input type="checkbox"/> ANE - Anesthesiology | <input type="checkbox"/> NRS - Neurosurgery |
| <input type="checkbox"/> CAR - Cardiology | <input type="checkbox"/> OBG - Obstetrics and Gynecology |
| <input type="checkbox"/> CTS - Cardiothoracic Surgery | <input type="checkbox"/> OPT - Ophthalmology |
| <input type="checkbox"/> CRC - Critical Care | <input type="checkbox"/> ORT - Orthopedics |
| <input type="checkbox"/> DOS - Dentistry/Oral Surgery | <input type="checkbox"/> OSS - Other Surgical Specialty |
| <input type="checkbox"/> DER - Dermatology | <input type="checkbox"/> OTH - Other Clinical Specialty |
| <input type="checkbox"/> ENT - Ear, Nose and Throat | <input type="checkbox"/> PAT - Pathology |
| <input type="checkbox"/> ERM - Emergency Medicine | <input type="checkbox"/> PED - Pediatrics |
| <input type="checkbox"/> FAP - Family Practice | <input type="checkbox"/> PLS - Plastic Surgery |
| <input type="checkbox"/> GAS - Gastroenterology | <input type="checkbox"/> PMR - Physical Medicine/Rehab |
| <input type="checkbox"/> GEN - General Surgery/Trauma | <input type="checkbox"/> PSC - Psychiatry |
| <input type="checkbox"/> IND - Infectious Diseases | <input type="checkbox"/> PUL - Pulmonology |
| <input type="checkbox"/> INM - Internal Medicine | <input type="checkbox"/> RAD - Radiology |
| <input type="checkbox"/> MSU - Other Medical Subspecialty | <input type="checkbox"/> URO - Urology |
| <input type="checkbox"/> NEP - Nephrology | <input type="checkbox"/> VAS - Vascular Surgery |
| <input type="checkbox"/> NEU - Neurology | |

Performs direct patient care (i.e., hands on, face-to-face contact with patients for the purpose of diagnosis, treatment and/or monitoring): ☐ Yes ☐ No

Assurance of Confidentiality: The voluntarily provided information obtained in this surveillance system that would permit identification of any individual or institution is collected with a guarantee that it will be held in strict confidence, will be used only for the purposes stated, and will not otherwise be disclosed or released without the consent of the individual, or the institution in accordance with Sections 304, 306 and 308(d) of the Public Health Service Act (42 USC 242b, 242k, and 242m(d)).

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Reports Clearance Officer, 1600 Clifton Rd., MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0666).



Healthcare Worker Demographic Data

Custom Fields

Label	
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Comments