



# Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2

EIP HCP ID: \_\_\_\_\_

IF PUI or COVID-19 CASE, ENTER STATE OR CDC ID: \_\_\_\_\_

CDC estimates the average public reporting burden for this collection of information as 30 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

## I. INTERVIEWER INFORMATION

1. Date of interview and form completion: MM / DD / YYYY
2. Interviewer name Last: \_\_\_\_\_ First: \_\_\_\_\_ Affiliation: \_\_\_\_\_  
Last: \_\_\_\_\_ First: \_\_\_\_\_ Affiliation: \_\_\_\_\_

## II. HEALTHCARE PERSONNEL (HCP) IDENTIFIERS (NOT TO BE TRANSMITTED TO CDC)

3. HCP Name: Last: \_\_\_\_\_ First: \_\_\_\_\_ 4. Phone no.:(\_\_\_\_\_) \_\_\_\_\_
5. HCP address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_
6. Facility Name: 1 \_\_\_\_\_  
2 \_\_\_\_\_  
3 \_\_\_\_\_  
4 \_\_\_\_\_

## III. HCP CASE STATUS INFORMATION

**READ ME FIRST!** Answer all questions on this form to the best of your knowledge. For dates, use a calendar (one is included) and any additional documentation or information you have available to help you remember and records dates as accurately as possible

7. Are you a healthcare personnel? (Refer to definition of healthcare personnel in the box)

- Yes  
 No  
 Not sure

8. Have you been diagnosed with COVID-19?

**Healthcare Personnel (HCP)** refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including:

- body substances
- contaminated medical supplies, devices, and equipment
- contaminated environmental surfaces
- contaminated air

For example, this includes any employee or contractor of a healthcare facility such as **physicians, nurses, students, respiratory therapists, phlebotomists, laboratory staff, as well as transport, food service, housekeeping, volunteers, and maintenance personnel.**



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- Yes
- No
- Not sure

9. Have you been tested for coronavirus (also known as SARS-CoV-2), the virus that causes COVID-19?

- Yes
- No; STOP the interview or form completion
- Not sure

10. Did someone (for example a doctor, nurse, or lab technician) collect swab(s) from your nose and/or throat for coronavirus (SARS-CoV-2) testing?

- Yes; answer Q10a
- No; go to Q11
- Not sure; go to Q11

10a. What was the coronavirus test result of the swab(s)? (if they collected swabs from you more than once, check "Positive" if at least one of the swabs tested positive for coronavirus; check "Negative" only if all swabs tested negative for coronavirus)

- I was not told of my results
- Positive; answer Q10b
- Negative; answer Q10c
- My results were unclear

10b. When did they collect the first swab that tested positive? MM / DD / YYYY  Not sure

10c. When did they collect the most recent swab that tested negative? MM / DD / YYYY  Not sure

11. Did someone (for example a doctor, nurse, or lab technician) collect blood from you for coronavirus (SARS-CoV-2) testing?

- Yes; answer Q11a
- No; to go Q12
- Not sure; go to Q12



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11a. What was the test result of your blood? (if they collected blood from you more than once, check “Positive” if at least one blood test was positive; check “Negative” only if all blood tests were negative)

- I was not told of my results  
 Positive; answer Q11b and Q11c  
 Negative; go to Q11d  
 My results were unclear

11b. Was your result positive for IgM or IgG antibodies?  IgM  IgG  Not sure

11c. When did they collect the first positive blood sample? MM / DD / YYYY  Not sure

11d. When did they collect the most recent negative blood sample? MM / DD / YYYY  Not sure

12. Did you have any close contact with a person(s) with COVID-19? (Refer to the definitions in the box)

- Yes; answer Q12a  
 No; go to Q13  
 Not sure; go to Q13

12a. Did the close contact occur in the healthcare facility where you work?

- Yes; answer Q12b, Q12c, and Q12d  
 No; go to Q13  
 Not sure; go to Q13

12b. When was your first close contact with a person(s) with COVID-19 in the healthcare facility where you work?

MM / DD / YYYY  Not sure

- A person with **suspected** COVID-19 is someone who has symptoms consistent with COVID-19, such as fever, cough, sore throat, runny nose, or shortness of breath but has not had a laboratory test for SARS-CoV-2
- A person with **confirmed** COVID-19 is someone who has a positive laboratory test for SARS-CoV-2
- For this interview, a “person with COVID-19” or a “COVID-19 patient” means a person with **suspected or confirmed** COVID-19.
- For this interview, **close contact** means: a) being within approximately 6 feet (2 meters) of a person with COVID-19 for at least a few minutes (such as caring for or visiting the patient; or sitting within 6 feet of the patient in a healthcare waiting area or room); or b) having unprotected direct contact with infectious secretions or excretions of the patient (e.g., being coughed on, touching used tissues with a bare hand).

12c. When was your last close contact with a person(s) with COVID-19 in the healthcare facility that you work? (record interview date or today’s date if close contact is still occurring) MM / DD / YYYY  Not sure

12d. Did your facility inform you of the exposure risk level of your close contact with a person(s) with COVID-19?



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- Yes; answer Q12d1
- No
- Not sure

12d1. What was your exposure risk level?     High /  Medium /  Low /  Not sure

13. Have you had any of the symptoms in the table below?

- No; go to Q15
- Yes; check all symptoms in the table below that apply; provide onset and resolution date for any symptom you had; write interview or form completion date as resolution date if you still have the symptoms.

- If you have been diagnosed with COVID-19, check the symptoms you had during the 14 days before or on the specimen collection date of your first positive coronavirus test. For example, if you had a nasal swab for coronavirus testing done on April 15, check any symptoms you had from April 1 through April 15. (MM / DD / YYYY to MM / DD / YYYY)
- If you have NOT been diagnosed with COVID-19, check the symptoms you had during the 14 days before or on the specimen collection date of your most recent NEGATIVE coronavirus test result. (MM / DD / YYYY to MM / DD / YYYY)

Symptom	When did the symptom begin?	When did the symptom end?
<input type="checkbox"/> Felt feverish	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Documented fever ≥100.0°F	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Chills	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Dry cough	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Productive cough	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Sore throat	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Runny nose	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Shortness of breath	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Muscle aches	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Headache	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Nausea or vomiting	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Diarrhea	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Abdominal pain	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Altered sense of smell or taste	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Other, _____	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure



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<input type="checkbox"/> Other, _____	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Other, _____	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure
<input type="checkbox"/> Other, _____	MM / DD / YYYY <input type="checkbox"/> Not sure	MM / DD / YYYY <input type="checkbox"/> Not sure

14. Based on the information on symptom dates in the table above, when was the first date you started to have COVID-19 symptom(s)? MM / DD / YYYY  Not sure

### IV. HCP COMMUNITY EXPOSURES

**READ ME FIRST (EIP Interview Instruction Only)**

- If the HCP was diagnosed with COVID-19 and had symptoms, complete Questions #15–39 with information for the 14 days before and the day of symptom onset (MM / DD / YYYY to MM / DD / YYYY)
- If the HCP was diagnosed with COVID-19 and did NOT have symptoms, complete Questions #15–39 with information for the 14 days before the specimen collection date of the first positive coronavirus test (MM / DD / YYYY to MM / DD / YYYY)
- If the HCP was NOT diagnosed with COVID-19 and had symptoms, complete Questions #15–39 with information for the 14 days before and the day of symptom onset (MM / DD / YYYY to MM / DD / YYYY)
- If the HCP was NOT diagnosed with COVID-19 and did NOT have symptoms, complete Questions #16–40 with information for the 14 days before the specimen collection date of the most recent NEGATIVE coronavirus test result (MM / DD / YYYY to MM / DD / YYYY)

15. Did you have close contact with a person(s) with COVID-19 outside of the healthcare facility(ies) where you work?

- Yes; answer Q15a, Q15b, and Q15c
- No; go to Q16
- Not sure; go to Q16

15a. When did you first and last have close contact with a person(s) with COVID-19 outside of the facility(ies)?

Date of first close contact MM / DD / YYYY  Not sure  
 Date of last close contact MM / DD / YYYY  Not sure

15b. What is your relationship to the person(s) with COVID-19? (Check all that apply)



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- Spouse/partner    Child    Parent    Other family    Friend    Medical provider    Co-worker  
 Classmate    Roommate    Contact only – no relationship    Other; can you specify? \_\_\_\_\_

15c. Where did the close contact with a person(s) with COVID-19 occur? (Check all that apply)

- Household    Work    Daycare    School/University    Transit    Rideshare    Hotel  
 Cruise Ship    Healthcare facility    Other; can you specify? \_\_\_\_\_

16. Did you travel away from home? (Check “Yes” if your return date is during the 14 days from MM / DD / YYYY to MM / DD / YYYY date range defined in guidance at top of page 5)

- Yes—domestic travel; can you specify destination(s)? \_\_\_\_\_  
 Yes—international travel; can you specify destination(s)? \_\_\_\_\_  
 No  
 Not sure

17. Did any of the following situations apply to you? If “Yes,” provide start and end dates for each situation.



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Did you...

Answer

Date Range

Did you...	Answer	Date Range
...household members, friends, acquaintances, or co-workers who had fever or respiratory symptoms (for example, cough, sore throat, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	From: MM / DD / YYYY To: MM / DD / YYYY <input type="checkbox"/> Not sure
...have close contact (such as caring for, speaking with, or touching) with any ill persons outside a healthcare facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	From: MM / DD / YYYY To: MM / DD / YYYY <input type="checkbox"/> Not sure
...attend a mass gathering (such as a religious event, wedding, party, dance, concert, banquet, festival, sports event, or other event)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	From: MM / DD / YYYY To: MM / DD / YYYY <input type="checkbox"/> Not sure
...use public transportation (for example, a bus, train, airplane)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	From: MM / DD / YYYY To: MM / DD / YYYY <input type="checkbox"/> Not sure
...use shared transportation (such as a car or van pool, ride share service)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	From: MM / DD / YYYY To: MM / DD / YYYY <input type="checkbox"/> Not sure
...attend or work at a school or daycare?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	From: MM / DD / YYYY To: MM / DD / YYYY <input type="checkbox"/> Not sure
...have a household member who attended school or daycare?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	From: MM / DD / YYYY To: MM / DD / YYYY <input type="checkbox"/> Not sure
...have close contact with a sick person who had contact with a person with COVID-19?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	From: MM / DD / YYYY To: MM / DD / YYYY <input type="checkbox"/> Not sure
...have close contact with a person who travelled internationally in the past 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure	From: MM / DD / YYYY To: MM / DD / YYYY <input type="checkbox"/> Not sure
...have close contact with a person who had a fever and/or other flu-like symptoms such as cough, runny nose, or sore throat and international travel in the preceding 2 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not sure If "Yes," where did the person travel? _____ _____	From: MM / DD / YYYY To: MM / DD / YYYY <input type="checkbox"/> Not sure



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### V. HCP EXPOSURES AND PATIENT CARE ACTIVITIES DURING WORK IN HEALTHCARE FACILITY

DRAFT



5. What is your role(s) in the healthcare facility(ies) where you work? (Check all that apply)



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- Chaplain
- Licensed practical nurse
- Physician assistant
- Environmental services worker
- Medical assistant
- Physician (intern/resident)
- Facilities/maintenance worker
- Nursing assistant
- Physician (fellow)
- Food services worker
- Nutritionist
- Respiratory therapist
- Laboratory personnel
- Occupational therapist
- Registered nurse

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- Gloves
- All the time
- Most of the time
- Sometimes
- Rarely or never
- Gown
- All the time
- Most of the time
- Sometimes
- Rarely or never
- N95 Respiratory
- All the time
- Most of the time
- Sometimes
- Rarely or never
- PAPR
- All the time
- Most of the time
- Sometimes
- Rarely or never
- Face mask
- All the time
- Other; can you specify? \_\_\_\_\_
- Sometimes
- Rarely or never
- Medical Laboratory Technician
- All the time
- Most of the time
- Sometimes
- Rarely or never

Remember! For this interview a "COVID-19 patient" is a person with suspected or confirmed COVID-19.

6. What type of healthcare facility(ies) do you work in? (Check all that apply)

- Hospital (including hospital emergency department)
- Outpatient dialysis unit or center
- Free-standing emergency room/department
- Nursing home or skilled nursing facility
- Urgent care clinic
- Other; can you specify? \_\_\_\_\_
- Outpatient clinic; can you specify clinic type? \_\_\_\_\_

7. In which area(s) of the facility(ies) do you normally work? (Check all that apply)

- Emergency room/department
- Laboratory
- Outpatient clinic area
- Endoscopy room
- Clinical pathology
- Pharmacy
- Intensive care unit
- Anatomic pathology
- Reception area
- Inpatient ward
- Other laboratory type
- Radiology department
- Unknown
- Operating room
- Other; can you specify? \_\_\_\_\_

8. Did you have any close contacts with COVID-19 patient(s) during work in your facility?

- Yes
- No; go to Q38
- Not sure; go to Q38

9. In which area(s) of the facility did your close contacts with COVID-19 patient(s) occur? (Check all that apply)

- During transport
- Laboratory
- Emergency room examination room
- Operating room
- Endoscopy room
- Outpatient examination room
- Inpatient ward patient room
- Radiology department
- Intensive care unit patient room
- Reception area
- Not sure
- Other; can you specify? \_\_\_\_\_



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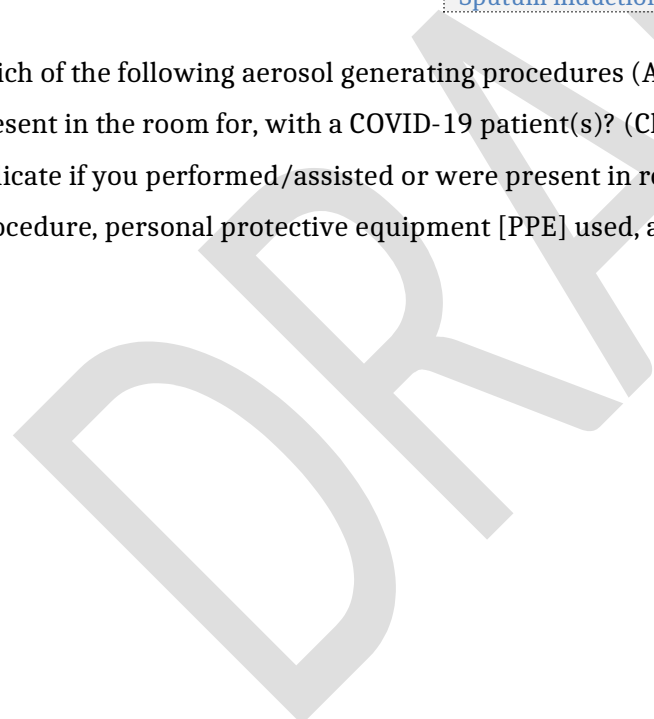
### VI. HCP PARTICIPATION IN AEROSOL-GENERATING PROCEDURES DURING WORK IN HEALTHCARE FACILITY

18. Did you participate in any aerosol-generating procedures (AGPs) for COVID-19 patient(s)? (Refer to examples of AGPs in the table)

- Yes; answer Q25a
  - No; go to Q26
  - Not sure; go to Q26

Examples of aerosol generating procedures
Airway suctioning
Breaking ventilation circuit (intentionally or unintentionally)
Bronchoscopy
Chest physiotherapy
Code / CPR
High-flow oxygen delivery
High-frequency oscillatory ventilation (HFOV)
Intubation
Mini-bronchoalveolar lavage (BAL)
Manual (bag) ventilation
Nebulizer treatments
Non-invasive positive-pressure ventilation (NIPPV, e.g., BiPAP, CPAP)
Other aerosol generating procedures
Sputum induction

25a. Which of the following aerosol generating procedures (AGPs) did you perform, assist with, or were you present in the room for, with a COVID-19 patient(s)? (Check all that apply; for each procedure selected, indicate if you performed/assisted or were present in room, number of procedures, average length of procedure, personal protective equipment [PPE] used, and frequency of PPE use)





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Procedure	PPE	Frequency of use			
<input type="checkbox"/> <b>Airway suctioning</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ Average length of procedure: _____minutes	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
<input type="checkbox"/> <b>Non-invasive positive-pressure ventilation (NIPPV, e.g., BiPAP, CPAP)</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Time spent in room during NIPPV: _____minutes	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
<input type="checkbox"/> <b>Manual (bag) ventilation</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never



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Number of procedures: _____ Average length of procedure: _____ minutes	N95 respirator <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> never <input type="checkbox"/> Rarely or never PAPR <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never Facemask <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never Goggles or face shield <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never
<input type="checkbox"/> <b>Nebulizer treatments</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ Average length of procedure: _____ minutes	Gloves <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never Gown <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never N95 respirator <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never PAPR <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never Facemask <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never Goggles or face shield <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never
<input type="checkbox"/> <b>Intubation</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ Average length of procedure: _____ minutes	Gloves <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never Gown <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never N95 respirator <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never PAPR <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never Facemask <input type="checkbox"/> All the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Sometimes <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never



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	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
never					
<input type="checkbox"/> <b>High-frequency oscillatory ventilation (HFOV)</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Time spent in room during HFOV: _____minutes	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
<input type="checkbox"/> <b>Chest physiotherapy</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ Average length of procedure: _____minutes	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
<input type="checkbox"/> <b>Mini-bronchoalveolar lavage (BAL)</b>	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2

EIP HCP ID: \_\_\_\_\_

IF PUI or COVID-19 CASE, ENTER STATE OR CDC ID: \_\_\_\_\_

<input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ Average length of procedure: _____minutes	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Gown</td> <td style="width: 15%;"><input type="checkbox"/> All the time</td> <td style="width: 15%;"><input type="checkbox"/> Most of the time</td> <td style="width: 15%;"><input type="checkbox"/> Sometimes</td> <td style="width: 15%;"><input type="checkbox"/> Rarely or never</td> </tr> <tr> <td>N95 respirator</td> <td><input type="checkbox"/> All the time</td> <td><input type="checkbox"/> Most of the time</td> <td><input type="checkbox"/> Sometimes</td> <td><input type="checkbox"/> Rarely or never</td> </tr> <tr> <td>PAPR</td> <td><input checked="" type="checkbox"/> All the time</td> <td><input checked="" type="checkbox"/> Most of the time</td> <td><input type="checkbox"/> Sometimes</td> <td><input type="checkbox"/> Rarely or never</td> </tr> <tr> <td>Facemask</td> <td><input type="checkbox"/> All the time</td> <td><input type="checkbox"/> Most of the time</td> <td><input type="checkbox"/> Sometimes</td> <td><input type="checkbox"/> Rarely or never</td> </tr> <tr> <td>Goggles or face shield</td> <td><input checked="" type="checkbox"/> All the time</td> <td><input type="checkbox"/> Most of the time</td> <td><input type="checkbox"/> Sometimes</td> <td><input type="checkbox"/> Rarely or never</td> </tr> </table>	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never	PAPR	<input checked="" type="checkbox"/> All the time	<input checked="" type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never	Goggles or face shield	<input checked="" type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never					
Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
PAPR	<input checked="" type="checkbox"/> All the time	<input checked="" type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
Goggles or face shield	<input checked="" type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
<input type="checkbox"/> <b>Breaking ventilation circuit (intentionally or unintentionally)</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of disconnections: _____ Average duration of each disconnection: _____minutes	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Gloves</td> <td style="width: 15%;"><input type="checkbox"/> All the time</td> <td style="width: 15%;"><input type="checkbox"/> Most of the time</td> <td style="width: 15%;"><input type="checkbox"/> Sometimes</td> <td style="width: 15%;"><input type="checkbox"/> Rarely or never</td> </tr> <tr> <td>Gown</td> <td><input type="checkbox"/> All the time</td> <td><input type="checkbox"/> Most of the time</td> <td><input type="checkbox"/> Sometimes</td> <td><input type="checkbox"/> Rarely or never</td> </tr> <tr> <td>N95 respirator</td> <td><input checked="" type="checkbox"/> All the time</td> <td><input checked="" type="checkbox"/> Most of the time</td> <td><input type="checkbox"/> Sometimes</td> <td><input type="checkbox"/> Rarely or never</td> </tr> <tr> <td>PAPR</td> <td><input type="checkbox"/> All the time</td> <td><input type="checkbox"/> Most of the time</td> <td><input type="checkbox"/> Sometimes</td> <td><input type="checkbox"/> Rarely or never</td> </tr> <tr> <td>Facemask</td> <td><input type="checkbox"/> All the time</td> <td><input type="checkbox"/> Most of the time</td> <td><input type="checkbox"/> Sometimes</td> <td><input type="checkbox"/> Rarely or never</td> </tr> <tr> <td>Goggles or face shield</td> <td><input type="checkbox"/> All the time</td> <td><input type="checkbox"/> Most of the time</td> <td><input type="checkbox"/> Sometimes</td> <td><input type="checkbox"/> Rarely or never</td> </tr> </table>	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never	N95 respirator	<input checked="" type="checkbox"/> All the time	<input checked="" type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
N95 respirator	<input checked="" type="checkbox"/> All the time	<input checked="" type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
<input type="checkbox"/> <b>Sputum induction</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ Average length of procedure: _____minutes	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Gloves</td> <td style="width: 15%;"><input type="checkbox"/> All the time</td> <td style="width: 15%;"><input type="checkbox"/> Most of the time</td> <td style="width: 15%;"><input type="checkbox"/> Sometimes</td> <td style="width: 15%;"><input type="checkbox"/> Rarely or never</td> </tr> <tr> <td>Gown</td> <td><input type="checkbox"/> All the time</td> <td><input type="checkbox"/> Most of the time</td> <td><input type="checkbox"/> Sometimes</td> <td><input type="checkbox"/> Rarely or never</td> </tr> <tr> <td>N95 respirator</td> <td><input type="checkbox"/> All the time</td> <td><input type="checkbox"/> Most of the time</td> <td><input type="checkbox"/> Sometimes</td> <td><input type="checkbox"/> Rarely or never</td> </tr> <tr> <td>PAPR</td> <td><input type="checkbox"/> All the time</td> <td><input type="checkbox"/> Most of the time</td> <td><input type="checkbox"/> Sometimes</td> <td><input type="checkbox"/> Rarely or never</td> </tr> </table>	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never										
Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											
PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never																											



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2

EIP HCP ID: \_\_\_\_\_

IF PUI or COVID-19 CASE, ENTER STATE OR CDC ID: \_\_\_\_\_

	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never <input type="checkbox"/> Rarely or never
	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never <input type="checkbox"/> Rarely or never

<input type="checkbox"/> <b>Bronchoscopy</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ Average length of procedure: _____minutes	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
<input type="checkbox"/> <b>High-flow oxygen delivery</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Time in room during delivery: _____minutes	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never

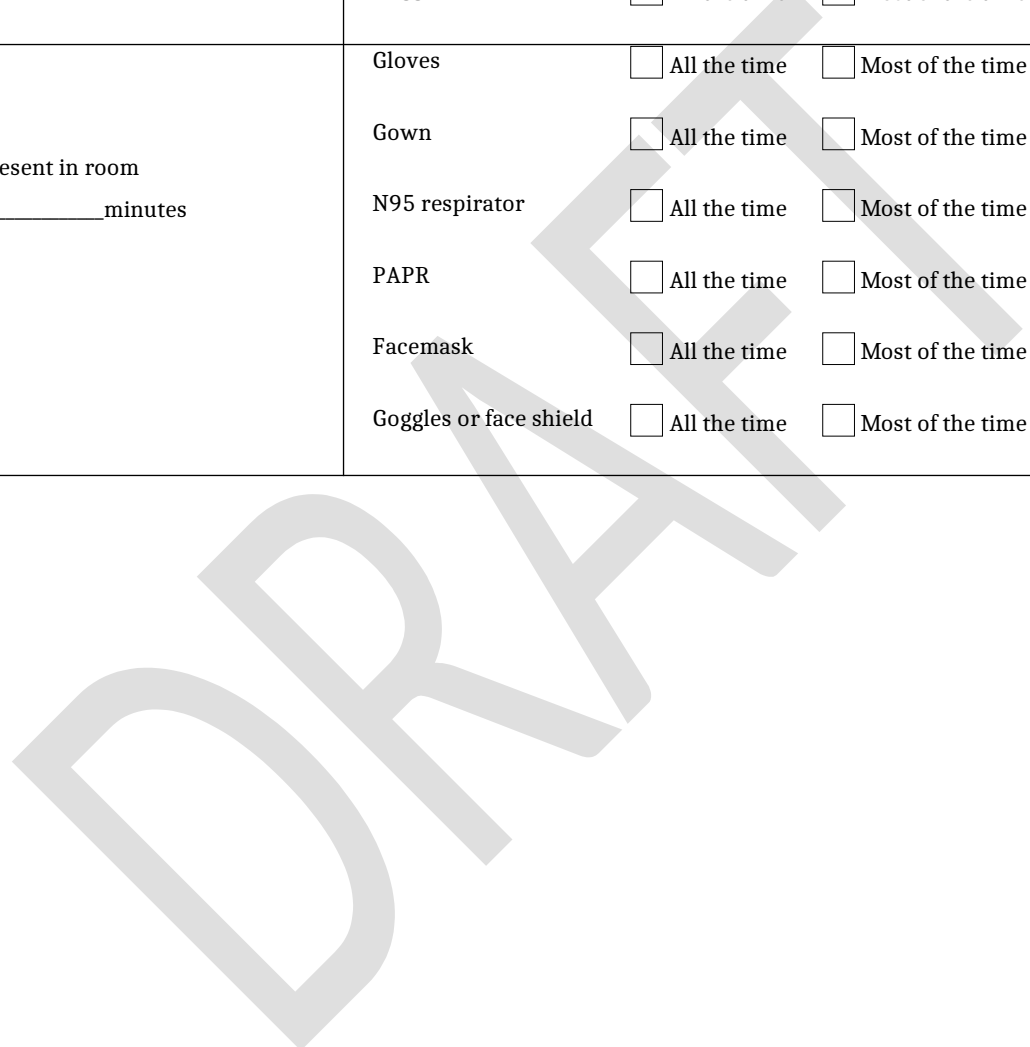


## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2

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IF PUI or COVID-19 CASE, ENTER STATE OR CDC ID: \_\_\_\_\_

	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
<input type="checkbox"/> <b>Other AGP; can you specify?</b> <hr style="width: 100%;"/> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Time in room during AGP: _____ minutes	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never







## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2

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19. What is the longest single (continuous) amount of time were you in a room or other location with COVID-19 patient(s)?

- Two minutes or less       Between 2 and 15 minutes       Between 15 and 30 minutes  
 Between 30 and 60 minutes       More than 60 minutes       Not sure

20. What is the total amount of time that you were in a room or other location with COVID-19 patient(s)?

Estimated: \_\_\_\_\_ minutes       Not sure

21. How close did you get to the COVID-19 patient(s)? (if you saw more than one COVID-19 patient and/or had more than one interaction with COVID-19 patient(s), give the closest distance)

- Within 6 feet or less       More than 6 feet away at all times       Not sure

22. How often were COVID-19 patient(s) wearing a facemask or were they intubated (i.e., have a tube inserted into their lungs for breathing) when you had contact with them? (Do not count masks used for delivery of oxygen or non-invasive positive pressure ventilation)

- All the time       Most of the time       Sometimes       Rarely or never       Not sure

29a. Which of the following was in place on COVID-19 patient(s) during your contacts?

- Surgical mask       N95 respirator (mask with closer fit)       Intubation (i.e., tube for breathing)  
 Other; can you specify? \_\_\_\_\_       Not sure

23. How often were COVID-19 patient(s) in an Airborne Infection Isolation Room (AIIR) (i.e., negative pressure room used for isolation) when you had contact with them?

- All the time       Most of the time       Sometimes       Rarely or never       Not sure

24. Did you have any concerns about your own PPE use during care for COVID-19 patient(s) (for example, did you have tears in your PPE, or did you need to change or replace your PPE while in the patient room)?

- Yes; can you describe your concern(s)? \_\_\_\_\_  
 No  
 Not sure

25. Did you reuse a respirator (for example, N95 respirator) during care for COVID-19 patient(s)? (Reuse means the practice of using the same respirator [usually a N95 respirator] for multiple encounters with



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2

EIP HCP ID: \_\_\_\_\_

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patients but removing it [doffing] after each encounter and storing it between encounters)

Yes  No  Not sure  Did not use a respirator

26. Were you fit tested for a respirator (for example, a N95 respirator)?

Yes; answer Q33a

No; go to Q34

Not sure; go to Q34

35a. Were you able to wear the respirator that you were fit tested for?

Yes  No  Not sure

27. Did you have any exposures of your mucous membranes (for example, your mouth or eyes) or skin to COVID-19 patient's respiratory secretions (i.e., liquid from mouth or nose), blood or other body fluids?

Yes; can you specify the fluid to which you were exposed? \_\_\_\_\_

No

Not sure

28. Did you have any percutaneous exposures (e.g., needle sticks or cuts) to COVID-19 patient's respiratory secretions (i.e., liquid from mouth or nose), blood or other body fluids?

Yes; can specify the fluid to which you were exposed? \_\_\_\_\_

No

Not sure

29. Did you have any direct skin-to-skin contact(s) with COVID-19 patient(s)?

Yes  No  Not sure

30. How would you describe your hand hygiene compliance (i.e., following hand washing guidance) during care for COVID-19 patient(s) or working in the room of COVID-19 patients?

All the time  Most of the time  Sometimes  Rarely or never

31. In your normal workday, how often were you able to practice social distancing with your co-workers?

Social distancing means staying 6 feet away from other persons.

All the time  Most of the time  Sometimes  Rarely or never



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2

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32. How often did you practice universal masking at work (e.g., wearing any type of mask for the entire shift)?

- All the time     Most of the time     Sometimes     Rarely or never

### VII. HCP DEMOGRAPHIC AND UNDERLYING MEDICAL CONDITIONS

33. What is your sex at birth?     Male     Female     Prefer not to answer

34. How old are you? \_\_\_\_\_ years     Prefer not to answer

35. What is your height? \_\_\_\_\_ feet \_\_\_\_\_ inches     Prefer not to answer

36. What is your weight? \_\_\_\_\_ pounds     Prefer not to answer

37. How would you define your race? (Check all that apply)

- American Indian or Alaska Native     Black or African American     White  
 Native Hawaiian/other Pacific Islander     Asian     Other race  
 Prefer not to answer

38. How would you define your ethnicity? (Check one)

- Hispanic or Latino     Not Hispanic or Latino     Prefer not to answer

39. Do you have any of the following underlying conditions?

Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Allergic rhinitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Chronic lung disease, other	<input type="checkbox"/> Yes; can you specify? _____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Heart condition	<input type="checkbox"/> Yes; can you specify?	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2

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				to answer
Diabetes mellitus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Chronic kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Hemodialysis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Autoimmune or rheumatologic disease	<input type="checkbox"/> Yes; can you specify? _____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Active cancer	<input type="checkbox"/> Yes; can you specify? _____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Solid organ transplant	<input type="checkbox"/> Yes; can you specify? _____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Hematopoietic stem cell transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Other immunosuppressing condition	<input type="checkbox"/> Yes; can you specify? _____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Chronic liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Pregnancy	<input type="checkbox"/> Yes; can you specify weeks? _____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer
Other medical condition(s)	<input type="checkbox"/> Yes; can you specify? _____	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	<input type="checkbox"/> Prefer not to answer

40. Are you taking any immunosuppressant medications (i.e., medications to reduce your body's immune response like corticosteroids, chemotherapy, or other medications)?

- Yes; can you specify? \_\_\_\_\_
- No
- Prefer not to answer



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2

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41. Are you taking any other medications?

- Yes; can you specify? \_\_\_\_\_
- No
- Prefer not to answer

42. Are you a current smoker (includes tobacco, e-cigarettes/vaping, or marijuana)?

- Yes; answer Q49a
- No; go to Q50
- Prefer not to answer; go to Q50

49a. How long have you been smoking? \_\_\_\_\_ years

43. Are you a former smoker (includes tobacco, e-cigarettes/vaping, marijuana)?

- Yes; answer Q50a and Q50b
- No; go to Q51
- Prefer not to answer; go to Q51

50a. How long did you smoke? \_\_\_\_\_ years

50b. How long since you quit smoking? \_\_\_\_\_  years or  months

44. Do you have any questions or additional details to share about the above patient care activities for COVID-19 patient(s)?

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# 2020

calendar2020i.com

January							February							March							April								
S	M	T	W	Th	F	S	S	M	T	W	Th	F	S	S	M	T	W	Th	F	S	S	M	T	W	Th	F	S		
			1	2	3	4							1	1	2	3	4	5	6	7				1	2	3	4		
5	6	7	8	9	10	11	2	3	4	5	6	7	8	8	9	10	11	12	13	14	5	6	7	8	9	10	11		
12	13	14	15	16	17	18	9	10	11	12	13	14	15	15	16	17	18	19	20	21	12	13	14	15	16	17	18		
19	20	21	22	23	24	25	16	17	18	19	20	21	22	22	23	24	25	26	27	28	19	20	21	22	23	24	25		
26	27	28	29	30	31		23	24	25	26	27	28	29	29	30	31					26	27	28	29	30				
May							June							July							August								
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					1	2		1	2	3	4	5	6				1	2	3	4							1		
3	4	5	6	7	8	9	7	8	9	10	11	12	13	5	6	7	8	9	10	11	2	3	4	5	6	7	8		
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17	18	19	20	21	22	23	21	22	23	24	25	26	27	19	20	21	22	23	24	25	16	17	18	19	20	21	22		
24	25	26	27	28	29	30	28	29	30					26	27	28	29	30	31		23	24	25	26	27	28	29		
31																					30	31							
September							October							November							December								
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			1	2	3	4	5					1	2	3	1	2	3	4	5	6	7				1	2	3	4	5
6	7	8	9	10	11	12	4	5	6	7	8	9	10	8	9	10	11	12	13	14	6	7	8	9	10	11	12		
13	14	15	16	17	18	19	11	12	13	14	15	16	17	15	16	17	18	19	20	21	13	14	15	16	17	18	19		
20	21	22	23	24	25	26	18	19	20	21	22	23	24	22	23	24	25	26	27	28	20	21	22	23	24	25	26		
27	28	29	30				25	26	27	28	29	30	31	29	30						27	28	29	30	31				