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

 Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Affiliation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **HEALTHCARE PERSONNEL (HCP) IDENTIFIERS (NOT TO BE TRANSMITTED TO CDC)**
 |
| 1. HCP Name: Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. Phone no.:(\_\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. HCP address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_\_\_\_\_\_\_ ZIP: \_\_\_\_\_\_\_\_\_\_\_\_
3. Facility Name: 1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **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.** |
|

|  |
| --- |
| **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.** |

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

[ ]  Yes [ ]  No; STOP the interview [ ]  Not sure; STOP the interview 1. Have you been diagnosed with COVID-19?

[ ]  Yes [ ]  No [ ]  Not sure1. Have you been tested for coronavirus (also known as SARS-CoV-2), the virus that causes COVID-19?

[ ]  Yes**[ ]** No; STOP the interview [ ]  Not sure 1. 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 unclear10b. 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  1. Did someone (for example a doctor, nurse, or lab technician) collect blood from you for coronavirus (SARS-CoV-2) testing?

[ ]  Yes; answer Q11a[ ]  No; go to Q12[ ]  Not sure; go to Q12 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 * 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 15 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).
1. Did you have any close contact with a person(s)

with COVID-19? (Refer to definitions in the box)[ ]  Yes; answer Q12a [ ]  No; go to Q13[ ]  Not sure; go to Q1312a. 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 12c. When was your last close contact with a person(s) with COVID-19 in the healthcare facility where 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?[ ]  Yes; answer Q12d1[ ]  No[ ]  Not sure  12d1. What was your exposure risk level? [ ]  High / [ ]  Medium / [ ]  Low / [ ]  Not sure 1. 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 and 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 and 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? |
| [ ]  Felt feverish | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Documented fever ≥100.0°F | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Chills | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Dry cough | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Productive cough | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Fatigue or malaise | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Sore throat | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Runny nose | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Shortness of breath | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Muscle aches | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Headache | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Chest pain/tightness | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Nausea or vomiting | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Diarrhea | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Abdominal pain | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Altered sense of smell or taste | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Congestion | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Loss of appetite | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Other, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Other, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Other, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |
| [ ]  Other, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | MM / DD / YYYY [ ]  Not sure | MM / DD / YYYY [ ]  Not sure |

1. 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
 |
| **INSTRUCTIONS FOR SECTIONS IV–VI** |
| **READ ME FIRST (EIP interviewer instructions)**1. If the HCP was diagnosed with COVID-19 and had symptoms, complete Questions #15–40 with information for the 14 days before and the day of symptom onset (MM / DD / YYYY to MM / DD / YYYY)
2. If the HCP was diagnosed with COVID-19 and did NOT have symptoms, complete Questions #15–40 with information for the 14 days before and on the specimen collection date of the first positive coronavirus test

(MM / DD / YYYY to MM / DD / YYYY) 1. If the HCP was NOT diagnosed with COVID-19 and had symptoms, complete Questions #15–40 with information for the14 days before and the day of symptom onset (MM / DD / YYYY to MM / DD / YYYY)
2. If the HCP was NOT diagnosed with COVID-19 and did NOT have symptoms, complete Questions #15–40 with information for the 14 days before and on the specimen collection date of the most recent NEGATIVE coronavirus test result (MM / DD / YYYY to MM / DD / YYYY)

REMINDER: For this interview, **close contact** means: a) being within approximately 6 feet (2 meters) of a person with COVID-19 for at least 15 minutes; 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). |
| 1. **HCP COMMUNITY EXPOSURES**
 |
| 1. 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 sure15b. What is your relationship to the person(s) with COVID-19? (Check all that apply)  [ ]  Spouse/partner [ ]  Child [ ]  Parent [ ]  Other family [ ]  Friend [ ]  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 [ ]  Daycare [ ]  School/University [ ]  Transit [ ]  Rideshare [ ]  Hotel  [ ]  Cruise ship [ ]  Healthcare facility (non-work reasons) [ ]  Other; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Did you travel away from home? (Check “Yes” if your return date is between MM / DD / YYYY and MM / DD / YYYY as 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 1. Did any of the following situations apply to you? If “Yes,” provide start and end dates for each situation.

|  |  |  |
| --- | --- | --- |
| **Did you:** | **Answer** | **Date Range** |
| Have any household members, friends, acquaintances, or co-workers who had fever or respiratory symptoms (for example, cough, sore throat, etc.)? | [ ]  Yes [ ]  No [ ]  Not sure | From: MM / DD / YYYY To: MM / DD / YYYY [ ]  Not sure |
| Have close contact (such as caring for, speaking with, or touching) with any ill persons outside a healthcare facility? | [ ]  Yes [ ]  No [ ]  Not sure | From: MM / DD / YYYY To: MM / DD / YYYY [ ]  Not sure |
| Attend a gathering that included people other than your household members (such as a religious event, wedding, party, sports event, or other event)?  | [ ]  Yes [ ]  No [ ]  Not sure | From: MM / DD / YYYY To: MM / DD / YYYY [ ]  Not sure |
| Use public transportation (for example, a bus, train, airplane) | [ ]  Yes [ ]  No [ ]  Not sure | From: MM / DD / YYYY To: MM / DD / YYYY [ ]  Not sure |
| Use shared transportation (such as a car or van pool, ride share service) | [ ]  Yes [ ]  No [ ]  Not sure | From: MM / DD / YYYY To: MM / DD / YYYY [ ]  Not sure |
| Attend or work at a school or daycare? | [ ]  Yes [ ]  No [ ]  Not sure | From: MM / DD / YYYY To: MM / DD / YYYY [ ]  Not sure |
| Have a household member who attended school or daycare?  | [ ]  Yes [ ]  No [ ]  Not sure | From: MM / DD / YYYY To: MM / DD / YYYY [ ]  Not sure |
| Have close contact with a sick person who had contact with a person with COVID-19?  | [ ]  Yes [ ]  No [ ]  Not sure | From: MM / DD / YYYY To: MM / DD / YYYY [ ]  Not sure |
| Have close contact with a person who travelled internationally in the past 2 weeks? | [ ]  Yes [ ]  No [ ]  Not sure | From: MM / DD / YYYY To: MM / DD / YYYY [ ]  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? | [ ]  Yes [ ]  No [ ]  Not sureIf “Yes,” where did the person travel? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | From: MM / DD / YYYY To: MM / DD / YYYY [ ]  Not sure |
|  |  |  |

 |
| 1. **HCP EXPOSURES AND PATIENT CARE ACTIVITIES DURING WORK IN HEALTHCARE FACILITY**

**(Remember to refer** **to the timeframe defined in the INSTRUCTIONS FOR SECTIONS IV–VI above)** |
|

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. What is your role(s) in the healthcare facility(ies) where you work? (Check all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| [ ]  Administrative staff  | [ ]  Licensed practical nurse | [ ]  Physician assistant |  |
| [ ]  Chaplain | [ ]  Medical assistant  | [ ]  Physician (intern/resident) |  |
| [ ]  Environmental services worker | [ ]  Nurse practitioner  | [ ]  Physician (fellow) |  |
| [ ]  Facilities/maintenance worker | [ ]  Nursing assistant | [ ]  Respiratory therapist |  |
| [ ]  Food services worker | [ ]  Nutritionist | [ ]  Registered nurse |  |
| [ ]  Home health aide/caregiver | [ ]  Occupational therapist | [ ]  Social worker  |  |
| [ ]  Laboratory personnel | [ ]  Pharmacist or pharmacy personnel | [ ]  Speech therapist |  |
|  [ ]  Cytotechnologist | [ ]  Phlebotomist | [ ]  Student |  |
|  [ ]  Histotechnologist | [ ]  Physician (attending) | [ ]  Ward clerk |  |
|  [ ]  Medical/clinical lab scientist | [ ]  Physical therapist |  |
|  [ ]  Medical laboratory technician | [ ]  Other; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  [ ]  PhD laboratory scientist |  |  |
|  [ ]  Other laboratory personnel  |  |  |

1. 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

|  |  |  |
| --- | --- | --- |
| [ ]  Administrative offices | [ ]  Laboratory  | [ ]  Pharmacy |
| [ ]  Dining room or cafeteria |  [ ]  Clinical pathology | [ ]  Private residence (home health) |
| [ ]  Emergency room/department  |  [ ]  Anatomic pathology  | [ ]  Radiology department  |
| [ ]  Endoscopy room  |  [ ]  Other laboratory type  | [ ]  Reception area |
| [ ]  Inpatient ward  | [ ]  Nursing home ward | [ ]  Other; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Intensive care unit  | [ ]  Operating room  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Kitchen  | [ ]  Outpatient clinic area  |  |

20a. Did you telework or work remotely from a location that is not a healthcare facility (such as from home)?[ ]  All the time[ ]  Some of the time[ ]  Not at all[ ]  Not sure20b. Did you have close contact with someone with COVID-19 who was not a patient during work in your facility? (Check all that apply) [ ]  Coworker with COVID-19 [ ]  Visitor with COVID-19 [ ]  Someone else (NOT a patient) with COVID-19; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  No [ ]  Not sure1. Did you have any close contacts with COVID-19 patient(s) during work in your facility?

[ ]  Yes**Reminder!** For this interview, a “COVID-19 patient” is a patient with **suspected or confirmed** COVID-19. [ ]  No; go to Q39 [ ]  Not sure; go to Q391. In which area(s) of the facility did your close contacts with COVID-19 patient(s) occur? (Check all that apply)

|  |  |
| --- | --- |
| [ ]  Dining room or cafeteria | [ ]  Nursing home common area  |
| [ ]  During transport  | [ ]  Nursing home resident room |
| [ ]  Emergency room examination room  | [ ]  Operating room  |
| [ ]  Endoscopy room  | [ ]  Outpatient examination room  |
| [ ]  Inpatient ward patient room | [ ]  Other; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| [ ]  Intensive care unit patient room  | [ ]  Private residence (home health) |
| [ ]  Laboratory  | [ ]  Radiology department  |
| [ ]  Not sure  | [ ]  Reception area |

1. Which of the following activities did you perform with COVID-19 patient(s)? (Check all that apply)

|  |  |
| --- | --- |
| [ ]  Arterial blood gas collection | [ ]  Insertion of peripheral line  |
| [ ]  Bathing  | [ ]  Lifting or positioning  |
| [ ]  Changing linen  | [ ]  Manipulation of oxygen face mask or tubing |
| [ ]  Chest tube (insert or remove) | [ ]  Manipulation of ventilator or tubing |
| [ ]  Cleaning the room  | [ ]  Participating in surgery |
| [ ]  Collecting respiratory specimens  | [ ]  Performing oral care (such as tooth brushing)  |
| [ ]  Drawing blood | [ ]  Performing physical exam  |
| [ ]  Extracorporeal Membrane Oxygenation (ECMO) | [ ]  Performing X-ray |
| [ ]  Emptying bedpan  | [ ]  Placing urinary catheter |
| [ ]  Feeding  | [ ]  Providing medication |
| [ ]  Giving injection | [ ]  Taking vital signs |
| [ ]  Hemodialysis | [ ]  Tracheostomy care |
| [ ]  Insertion of central line | [ ]  Transport in the facility |
| [ ]  Insertion of nasogastric tube | [ ]  Other; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. What Personal Protective Equipment (PPE) were you wearing during the above patient care activities for COVID-19 patient(s)? (Check the frequency of use for each PPE item)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles/face shield | [ ]  All the time | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

1. Did you wear any alternative or improvised equipment during care of COVID-19 patients?

[ ]  Yes; answer Q25a [ ]  No; go to Q26[ ]  Not sure; go to Q26 25a. If yes, what alternative or improvised equipment did you wear? (Check all that apply)[ ]  Face covering that was not a medical mask or respirator, such as a cloth face covering, bandana, balaclava[ ]  A covering for clothing other than a medical gown, such as a lab coat, trash bag, or raincoat[ ]  Improvised eye protection, such as a homemade face shield[ ]  Other; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

 |
| 1. **HCP PARTICIPATION IN AEROSOL-GENERATING PROCEDURES DURING WORK IN HEALTHCARE FACILITY**

**(Remember to refer** **to the timeframe defined in the INSTRUCTIONS FOR SECTIONS IV–VI above)** |
| **READ ME FIRST (EIP interviewer instructions)**For this section, refer to these examples of aerosol-generating procedures (AGPs):* 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)
* Sputum induction
* Certain dental procedures
* Other aerosol generating procedures
 |
| 1. Did you participate in any aerosol-generating procedures (AGPs) for COVID-19 patient(s)? (Refer to examples of AGPs in the table)

[ ]  Yes; answer Q26a[ ]  No; go to Q27 [ ]  Not sure; go to Q2726a. 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) |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|

|  **Procedure** |  **PPE Frequency of use**  |
| --- | --- |
| **[ ]  Airway suctioning**  [ ]  Performed or assisted [ ]  Present in room Number of procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average length of procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |
| [ ]  **Non-invasive positive-pressure ventilation (NIPPV, e.g., BiPAP, CPAP)**  [ ]  Performed or assisted [ ]  Present in room Time spent in room during NIPPV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |
| [ ]  **Manual (bag) ventilation**  [ ]  Performed or assisted [ ]  Present in room Number of procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average length of procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |
| [ ]  **Nebulizer treatments** [ ]  Performed or assisted [ ]  Present in room Number of procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average length of procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |
| [ ]  **Intubation**  [ ]  Performed or assisted [ ]  Present in room Number of procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average length of procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |

 |

|  |  |
| --- | --- |
|  **Procedure** |  **PPE Frequency of use**  |
| [ ]  **High-frequency oscillatory ventilation (HFOV)**  [ ]  Performed or assisted [ ]  Present in room Time spent in room during HFOV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |
| [ ]  **Chest physiotherapy**  [ ]  Performed or assisted [ ]  Present in room Number of procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average length of procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |
| [ ]  **Mini-bronchoalveolar lavage (BAL)**  [ ]  Performed or assisted [ ]  Present in room Number of procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average length of procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |
| [ ]  **Breaking ventilation circuit (intentionally or unintentionally)** [ ]  Performed or assisted [ ]  Present in room Number of disconnections: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average duration of each disconnection: \_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |
| [ ]  **Sputum induction**  [ ]  Performed or assisted [ ]  Present in room Number of procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average length of procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |

|  |  |
| --- | --- |
|  **Procedure** |  **PPE Frequency of use**  |
| [ ]  **Bronchoscopy**  [ ]  Performed or assisted [ ]  Present in room Number of procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Average length of procedure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |
| [ ]  **High-flow oxygen delivery** [ ]  Performed or assisted [ ]  Present in room Time in room during delivery: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |
| [ ]  **Other AGP; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** [ ]  Performed or assisted [ ]  Present in room Number of procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time in room during AGP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |
| [ ]  **Other AGP; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** [ ]  Performed or assisted [ ]  Present in room Number of procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time in room during AGP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |
| [ ]  **Other AGP; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** [ ]  Performed or assisted [ ]  Present in room Number of procedures: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time in room during AGP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 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 respirator | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| PAPR | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Facemask | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |
| Goggles or face shield | [ ]  All the time  | [ ]  Most of the time | [ ]  Sometimes  | [ ]  Rarely or never |

 |

|  |
| --- |
| 1. What is the longest single (continuous) amount of time you were 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 1. What is the total amount of time that you were in a room or other location with COVID-19 patient(s)?

Estimated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_minutes [ ]  Not sure1. 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-19patient(s), give the closest distance)

[ ]  Within 6 feet or less [ ]  More than 6 feet away at all times [ ]  Not sure 1. How often were COVID-19 patient(s) wearing a facemask or cloth face covering 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  30a. Which of the following was in place on COVID-19 patient(s) during your contacts? (Check all that apply)[ ]  Surgical or procedure mask [ ]  Cloth face covering [ ]  N95 respirator [ ]  Endotracheal or nasotracheal tube (for invasive mechanical ventilation)[ ]  Other; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  None  [ ]  Not sure1. 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 1. 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 1. Did you use any of the following practices when wearing an N95 respirator? (Check all that apply)

[ ]  I wore one N95 respirator for repeated close contact encounters with several patients, without removing the respirator between patient encounters.[ ]  I wore one N95 respirator for repeated close contact encounters with several patients, but I usually removed it (‘doffed’) after each encounter.[ ]  I wore the same N95 respirator on multiple workdays.         [ ]  I wore a respirator, but I did not use any of these practices. [ ]  I did not use a respirator.[ ]  Other; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_1. Were you fit tested for a respirator (for example, a N95 respirator)?

[ ]  Yes – during the past year; answer Q34a[ ]  Yes – more than one year ago; answer Q34a[ ]  No; go to Q35 [ ]  Not sure; go to Q35 34a. During the timeframe of interest, were you able to wear the respirator that you were fit tested for while caring for COVID-19 patients?  [ ] Yes [ ] No [ ] Not sure [ ]  Did not use a respirator1. 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 1. 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 1. Did you have any direct skin-to-skin contact(s) with COVID-19 patient(s)?

[ ]  Yes [ ]  No [ ]  Not sure 1. 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 never1. 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 never1. 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 |
| 1. **HCP DEMOGRAPHICS AND UNDERLYING MEDICAL CONDITIONS**
 |
| 1. What sex were you assigned at birth, on your original birth certificate?

[ ]  Male [ ]  Female [ ]  Refused [ ]  I don’t know 41a. Do you currently describe yourself as male, female, or transgender?[ ]  Male [ ]  Female [ ]  Transgender [ ]  None of these1. How old are you? \_\_\_\_\_\_\_ years [ ]  Prefer not to answer
2. What is your height? \_\_\_\_\_\_\_\_\_\_\_ feet \_\_\_\_\_\_\_\_\_ inches [ ]  Prefer not to answer
3. What is your weight? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ pounds [ ]  Prefer not to answer

**READ ME FIRST:** Questions 45 and 46 ask about your race and ethnicity based on federal government reporting standards. 1. How would you define your ethnicity? (Check one)

[ ]  Hispanic or Latino [ ]  Not Hispanic or Latino [ ]  Prefer not to answer **(Not to be read by INTERVIEWER)**1. How would you define your race? (Check all that apply)

|  |  |
| --- | --- |
| [ ]  American Indian or Alaska Native  | [ ]  White  |
| [ ]  Asian  | [ ]  Prefer not to answer **(Not to be read by INTERVIEWER)** |
| [ ]  Black or African American[ ]  Native Hawaiian/other Pacific Islander |  |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Asthma | [ ]  Yes | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Allergic rhinitis | [ ]  Yes | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Chronic Obstructive Pulmonary Disease (COPD) | [ ]  Yes | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Chronic lung disease, other | [ ]  Yes; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Hypertension | [ ]  Yes | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Heart condition | [ ]  Yes; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Diabetes mellitus | [ ]  Yes | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Chronic kidney disease | [ ]  Yes | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Hemodialysis | [ ]  Yes | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Autoimmune or rheumatologic disease | [ ]  Yes; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Active cancer | [ ]  Yes; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Solid organ transplant  | [ ]  Yes; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Hematopoietic stem cell transplant  | [ ]  Yes | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Other immunosuppressing condition | [ ]  Yes; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Chronic liver disease | [ ]  Yes | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Pregnancy | [ ]  Yes; can you specify weeks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |
| Other medical condition(s) | [ ]  Yes; can you specify? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  No | [ ] Unknown | [ ]  Prefer not to answer |

1. 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 answer1. Are you taking any other medications?

[ ]  Yes; can you specify?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  No [ ]  Prefer not to answer1. Are you a current smoker (includes tobacco, e-cigarettes/vaping, or marijuana)?

[ ]  Yes; answer Q50a [ ]  No; go to Q51[ ]  Prefer not to answer; go to Q5150a. How long have you been smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ years1. Are you a former smoker (includes tobacco, e-cigarettes/vaping, marijuana)?

[ ]  Yes; answer Q51a and Q51b [ ]  No; go to Q52[ ]  Prefer not to answer; go to Q52  51a. How long did you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ years  51b. How long since you quit smoking? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  years or [ ]  months1. When was the last time you received flu vaccine? MM/YYYY    [ ]  Not sure

[ ]  Never received flu vaccine      |
| 1. **ADDITIONAL INFORMATION**
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| 1. Do you have any additional information you would like to share?

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Public reporting burden of this collection of information is estimated to average 32 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/ATSDR Information Collection Request Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-1296).

