



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

OMB: 0920-1296  
Exp: 10/31/2020

EIP HCP ID: \_\_\_\_\_ COVID-NET ID: \_\_\_\_\_ CDC/STATE CASE ID: \_\_\_\_\_

## 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.

**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.**

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

Yes



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- No; STOP the interview
- Not sure; STOP the interview

8. Have you been diagnosed with COVID-19?

- 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
- 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; go to Q12



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CDC/STATE CASE ID: \_\_\_\_\_

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

12. 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 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 **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).

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



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OMB: 0920-1296  
Exp: 10/31/2020

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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

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 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?
<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"/> Fatigue or malaise	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"/> Chest pain/tightness	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



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OMB: 0920-1296  
Exp: 10/31/2020

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

COVID-NET ID: \_\_\_\_\_

CDC/STATE CASE ID: \_\_\_\_\_

<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"/> Congestion	MM / DD / YYYY	<input type="checkbox"/> Not sure	MM / DD / YYYY	<input type="checkbox"/> Not sure
<input type="checkbox"/> Loss of appetite	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
<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

## 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)
- 3) If the HCP was NOT 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)
- 4) 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 a few 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).

## IV. HCP COMMUNITY EXPOSURES



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OMB: 0920-1296  
Exp: 10/31/2020

EIP HCP ID: \_\_\_\_\_ COVID-NET ID: \_\_\_\_\_ CDC/STATE CASE ID: \_\_\_\_\_

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)

- 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? \_\_\_\_\_

16. 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

17. 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.)?	<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
<b>Attend a gathering that included people</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	From: MM / DD / YYYY



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OMB: 0920-1296  
Exp: 10/31/2020

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

COVID-NET ID: \_\_\_\_\_

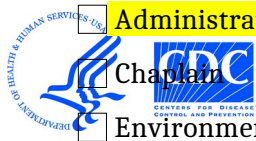
CDC/STATE CASE ID: \_\_\_\_\_

<p style="background-color: yellow;">other than your household members (such as a religious event, wedding, party, sports event, or other event)?</p>	<input type="checkbox"/> Not sure	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

**V. 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)

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



Administrative staff

Chaplain

Environmental services worker

Licensed practical nurse

Medical assistant

Nurse practitioner

Physician assistant

Physician (intern/resident)

Physician (fellow)

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

OMB: 0920-1296  
Expires 12/31/2020

Facilities/maintenance worker

COVID-NET ID:  ID: \_\_\_\_\_

CDC/STATE CASE ID: \_\_\_\_\_

Food services worker

Nutritionist **Reminder! For this interview, a "COVID-19 patient" is a patient with suspected or confirmed COVID-19.**  Registered nurse  a patient with

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

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)

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 sure

20b. 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? \_\_\_\_\_





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Exp: 10/31/2020

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

## VI. HCP PARTICIPATION IN 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

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 Q26a
- No; go to Q27
- Not sure; go to Q27

26a. 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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EIP HCP ID: \_\_\_\_\_

COVID-NET ID: \_\_\_\_\_

CDC/STATE CASE ID: \_\_\_\_\_

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 _____ minutes	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> 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"/> <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 _____ minutes	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> 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"/> <b>Manual (bag) ventilation</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ Average length of procedure: _____ minutes _____ minutes	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> 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"/> <b>Nebulizer treatments</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ Average length of procedure: _____ minutes _____ minutes	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> never	
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> 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	



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COVID-NET ID: \_\_\_\_\_

CDC/STATE CASE ID: \_\_\_\_\_

Procedure	PPE	Frequency of use			
<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	never <input type="checkbox"/>
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	never <input type="checkbox"/>
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	never <input type="checkbox"/>
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	never <input type="checkbox"/>
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	never <input type="checkbox"/>
	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	never <input type="checkbox"/>





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

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

COVID-NET ID: \_\_\_\_\_

CDC/STATE CASE ID: \_\_\_\_\_

	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>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	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>Sputum induction</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



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

OMB: 0920-1296  
Exp: 10/31/2020

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

COVID-NET ID: \_\_\_\_\_

CDC/STATE CASE ID: \_\_\_\_\_

Procedure	PPE	Frequency of use			
<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 Gown N95 respirator PAPR Facemask Goggles or face shield	<input type="checkbox"/> All the time <input type="checkbox"/> All the time <input type="checkbox"/> All the time <input type="checkbox"/> All the time <input type="checkbox"/> All the time <input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never <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 Gown N95 respirator PAPR Facemask Goggles or face shield	<input type="checkbox"/> All the time <input type="checkbox"/> All the time <input type="checkbox"/> All the time <input type="checkbox"/> All the time <input type="checkbox"/> All the time <input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never
<input type="checkbox"/> <b>Other AGP; can you specify? _____</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ Time in room during AGP: _____minutes	Gloves Gown N95 respirator PAPR	<input type="checkbox"/> All the time <input type="checkbox"/> All the time <input type="checkbox"/> All the time <input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time <input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes <input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never <input type="checkbox"/> Rarely or never



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

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

COVID-NET ID: \_\_\_\_\_

CDC/STATE CASE ID: \_\_\_\_\_

	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>Other AGP; can you specify?</b> _____ <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ 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
<input type="checkbox"/> <b>Other AGP; can you specify?</b> _____ <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ 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

OMB: 0920-1296  
Exp: 10/31/2020

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

COVID-NET ID: \_\_\_\_\_

CDC/STATE CASE ID: \_\_\_\_\_

19. 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

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 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 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





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

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

COVID-NET ID: \_\_\_\_\_

CDC/STATE CASE ID: \_\_\_\_\_

25. 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? \_\_\_\_\_

26. 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 respirator

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



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

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

COVID-NET ID: \_\_\_\_\_

CDC/STATE CASE ID: \_\_\_\_\_

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

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 DEMOGRAPHICS AND UNDERLYING MEDICAL CONDITIONS

33. 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 these

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

**READ ME FIRST:** Questions 45 and 46 ask about your race and ethnicity based on federal government reporting standards.

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

- Hispanic or Latino     Not Hispanic or Latino

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

- American Indian or Alaska Native                       White
- Asian
- Black or African American
- Native Hawaiian/other Pacific Islander



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

OMB: 0920-1296  
Exp: 10/31/2020

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

COVID-NET ID: \_\_\_\_\_

CDC/STATE CASE ID: \_\_\_\_\_

**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
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

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

COVID-NET ID: \_\_\_\_\_

CDC/STATE CASE ID: \_\_\_\_\_

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 **Q50a**
- No; go to **Q51**
- Prefer not to answer; go to **Q51**

50a. How long have you been smoking? \_\_\_\_\_ years

43. 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  months

44. When was the last time you received flu vaccine? **MM/YYYY**  **Not sure**

**Never received flu vaccine**

## VIII. **ADDITIONAL INFORMATION**

45. 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).



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								
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		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		
10	11	12	13	14	15	16	14	15	16	17	18	19	20	12	13	14	15	16	17	18	9	10	11	12	13	14	15		
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								
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	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				