



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

NEW EIP HCP ID: \_\_\_\_\_ FIRST 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 (EIP interviewer instructions)

- 1) Tell HCP to answer all questions on this form to the best of their knowledge.
- 2) For dates, tell HCP to use a calendar and any additional documentation or information they have available to help them remember and records dates as accurately as possible.
- 3) Record or calculate important reference dates below:
  - A. The date of initial interview for this project was: MM / DD / YYYY
  - B. The date of collection of the initial swab that tested positive for SARS-CoV-2 by PCR was:  
MM / DD / YYYY
  - C. The symptom onset date of your initial SARS-CoV-2 infection was: MM / DD / YYYY or  
 No symptoms reported
  - D. The initial infection end date is: MM / DD / YYYY (the date of collection of the initial swab that tested positive for SARS-CoV-2 by PCR [B, above] + 60 days if HCP did NOT report any symptoms during the initial interview OR symptom onset date [C, above] + 60 days if HCP reported symptoms during the initial interview)

#### “Possible reinfection” definition:

A HCP case who has collection of a positive SARS-CoV-2 PCR test at least 60 days after the symptom onset date or (if symptoms were not reported) the first positive SARS-CoV-2 PCR test collection date of the prior infection during the project period.



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

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

7. On or after MM / DD / YYYY (insert initial infection end date), did you ever test positive for SARS-CoV-2 by PCR on a swab collected from your throat or nose?

- Yes; go to Q7a
- No; stop interview (NOT a reinfection)
- Not sure; stop interview (NOT a reinfection)

7a. On or after MM / DD / YYYY (insert initial infection end date), when was the first swab collected that tested positive for SARS-CoV-2 by PCR?

MM / DD / YYYY (this is the possible reinfection date)  Not sure

8. Did you have any symptoms in the 14 days before and on the possible reinfection date? MM / DD / YYYY to MM / DD / YYYY

- No; go to Q9
- Yes; answer Q8a and Q8b.

8a. What symptoms did you have?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Felt feverish                                 | <input type="checkbox"/> Sore throat          | <input type="checkbox"/> Nausea or vomiting              |
| <input type="checkbox"/> Documented fever $\geq 100.0^{\circ}\text{F}$ | <input type="checkbox"/> Runny nose           | <input type="checkbox"/> Diarrhea                        |
| <input type="checkbox"/> Chills  | <input type="checkbox"/> Shortness of breath  | <input type="checkbox"/> Abdominal pain                  |
| <input type="checkbox"/> Dry cough                                     | <input type="checkbox"/> Muscle aches         | <input type="checkbox"/> Altered sense of smell or taste |
| <input type="checkbox"/> Productive cough                              | <input type="checkbox"/> Headache             | <input type="checkbox"/> Congestion                      |
| <input type="checkbox"/> Fatigue or malaise                            | <input type="checkbox"/> Chest pain/tightness | <input type="checkbox"/> Loss of appetite                |

Other; specify: \_\_\_\_\_

Other; specify: \_\_\_\_\_

Other; specify: \_\_\_\_\_

Other; specify: \_\_\_\_\_

8b. What was the first date you started to have these symptoms? MM / DD / YYYY  Not sure

**INSTRUCTIONS FOR SECTIONS IV-VI**  
**READ ME FIRST (EIP interviewer instructions)**



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

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

### 1) Determine the “timeframe of interest” for answering Questions 9–33, as follows:

- If the HCP had symptoms reported in Q8a, the timeframe of interest is defined by the 14 days before and on the day of symptom onset reported in Q8b (MM / DD / YYYY to MM / DD / YYYY)
- If the HCP did NOT report symptoms in Q8a, the timeframe of interest is defined by the 14 days before and on the possible reinfection date reported in question 7a above (MM / DD / YYYY to MM / DD / YYYY)

### 2) Review the following definitions:

- A person with **suspected** COVID-19 is someone who has symptoms consistent with COVID-19 but has not had a laboratory test for SARS-CoV-2.
- A person with **confirmed** COVID-19 is someone who has a positive laboratory test for SARS-CoV-2.
- For this interview, a “person with COVID-19” or a “COVID-19 patient” means a person with **suspected or confirmed** COVID-19.
- For this interview, **close contact** means: a) being within approximately 6 feet (2 meters) of a person with COVID-19 for at least a few minutes; 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 DURING TIMEFRAME OF INTEREST

(MM / DD / YYYY to MM / DD / YYYY)

9. Did you have close contact with a person(s) with COVID-19 outside of the healthcare facility(ies) where you worked during the timeframe of interest?

- Yes; answer Q9a and Q9b
- No; go to Q10
- Not sure; go to Q10

9a. 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? \_\_\_\_\_

9b. 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? \_\_\_\_\_

10. Did any of the following situations apply to you during the timeframe of interest? (Check all that apply)

- Attended a gathering that included people other than your household members (such as a religious event, wedding, party, sports event)



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

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

- Used public transportation (for example, a bus, train, airplane)
- Used shared transportation (such as a car or van pool, ride share service)
- Had close contact with a child who attended school or daycare
- Traveled overnight domestically or internationally
- Other; can you specify? \_\_\_\_\_
- None of these apply

**V. HCP EXPOSURES AND PATIENT CARE ACTIVITIES DURING WORK IN HEALTHCARE FACILITY DURING TIMEFRAME OF INTEREST (MM / DD / YYYY to MM / DD / YYYY)**

5. Did your healthcare personnel role(s) change since the initial interview?



No; go to Q12



Yes; answer Q11

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

## Possible Reinfection Form

11a. What is your role(s) in the healthcare facility(ies) where you work? (Check all that apply)  
NEW EIP HCP ID: \_\_\_\_\_ FIRST EIP HCP ID: \_\_\_\_\_ COVID-NET ID: \_\_\_\_\_ CDC/STATE CASE ID: \_\_\_\_\_

Administrative staff  Licensed practical nurse  Physician assistant

Gloves  All the time  Most of the time  Sometimes  Rarely or never  
 Chaplain  Medical assistant **Reminder!** For this interview, a "COVID-19 patient" is a patient

Gown  All the time  Most of the time  Sometimes  Rarely or never  
 Environmental services worker  Nurse practitioner **with suspected or confirmed COVID-19**  Physician (intern/resident)

N95 respirator  All the time  Most of the time  Sometimes  Rarely or never  
 Facilities/maintenance worker  Nursing assistant  Respiratory therapist

PAPR  All the time  Most of the time  Sometimes  Rarely or never  
 Food services worker  Nutritionist  Registered nurse

Facemask  All the time  Most of the time  Sometimes  Rarely or never  
 Home health aide/caregiver  Occupational therapist  Social worker

Goggles/face shield  All the time  Most of the time  Sometimes  Rarely or never  
 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. Did the type of healthcare facility where you work change since the initial interview?

No; go to Q13

Yes; answer Q12a

12a. What type of healthcare facility(ies) do you work in now? (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. Do you work in a different area(s) in the facility (e.g., ICU, Emergency Room, etc.) than at the time of your initial interview?

No; go to question 14

Yes; answer question 13a

13a. In which area(s) of the facility(ies) do you normally work now? (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 \_\_\_\_\_



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

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

17. Did you wear any alternative or improvised equipment to protect yourself during care of COVID-19 patients?

No; go to Q21

Yes; answer Q20a

20a. 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? \_\_\_\_\_

VI. HCP PARTICIPATION IN AEROSOL-GENERATING PROCEDURE IN A HEALTHCARE FACILITY DURING TIMEFRAME OF INTEREST (MM / DD / YYYY to MM / DD / YYYY)

### **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 (i.e., perform/assist or present in room) in any aerosol-generating procedures (AGPs) for COVID-19 patient(s)? (Refer to examples of AGPs above)

Yes; answer Q21a

No; go to Q22

Not sure; go to Q22

20a. Which of the following 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



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

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

were present in room, number of procedures, average length of procedure, personal protective equipment [PPE] used, and frequency of PPE use).



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

OMB: 0920-1296  
Exp: X10/31/2020  
Version: 07/17/2020

NEW EIP HCP ID: \_\_\_\_\_ FIRST 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	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
<input type="checkbox"/> <b>Non-invasive positive-pressure ventilation (NIPPV, e.g., BiPAP, CPAP)</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Time spent in room during NIPPV: _____ minutes	Gloves	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Gown	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	N95 respirator	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	PAPR	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Facemask	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
	Goggles or face shield	<input type="checkbox"/> All the time	<input type="checkbox"/> Most of the time	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely or never
<input type="checkbox"/> <b>Manual (bag) ventilation</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room 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



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

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

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

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

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



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

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

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

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

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

Procedure	PPE	Frequency of use			
<input type="checkbox"/> <b>High-frequency oscillatory ventilation (HFOV)</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Time spent in room during HFOV: _____minutes	Gloves Gown N95 respirator PAPR Facemask Goggles or face shield	<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"/> 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"/> <b>Chest physiotherapy</b> <input type="checkbox"/> Performed or assisted <input type="checkbox"/> Present in room Number of procedures: _____ Average length of procedure: _____minutes	Gloves Gown N95 respirator PAPR Facemask Goggles or face shield	<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"/> 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"/> <b>Mini-bronchoalveolar lavage (BAL)</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	<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"/> 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



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

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

	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>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: Possible Reinfection Form

OMB: 0920-1296  
Exp: X10/31/2020  
Version: 07/17/2020

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

FIRST 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"/> 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"/> <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"/> 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"/> <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	<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"/> 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



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

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

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

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

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

	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
<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: Possible Reinfection Form

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

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

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

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



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

OMB: 0920-1296  
Exp: 10/31/2020  
Version: 07/17/2020

NEW EIP HCP ID: \_\_\_\_\_ FIRST EIP HCP ID: \_\_\_\_\_ IF COVID-19 CASE, STATE OR CDC 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. 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

**23a.** 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

21. 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

22. 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

23. 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 for multiple workdays.  
 I wore a respirator, but I did not use any of these practices.  
 I did not use a respirator.



## Assessment of Healthcare Personnel Exposed to or Infected with SARS-CoV-2: Possible Reinfection Form

NEW EIP HCP ID: \_\_\_\_\_ FIRST EIP HCP ID: \_\_\_\_\_ IF COVID-19 CASE, STATE OR CDC ID: \_\_\_\_\_

Other; can you specify? \_\_\_\_\_

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

Yes – during the past year; answer Q27a

Yes – more than one year ago; answer Q27a

No; go to Q28

Not sure; go to Q28

27a. 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

25. Did you have any exposures of your mucous membranes (for example, your mouth or eyes) or skin to COVID-19 patients' 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

26. Did you have any percutaneous exposures (e.g., needle sticks or cuts) to COVID-19 patients' 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

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

Yes  No  Not sure

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

All the time  Most of the time  Sometimes  Rarely or never

29. In your normal workday, how often were you able to practice social distancing with your co-workers?  
Social distancing means staying at least 6 feet away from other persons.

All the time  Most of the time  Sometimes  Rarely or never





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		