COVID-19 REPORTING FORM

Please complete and return to the Safety & Risk Management Department via e-mail covid19@sbccd.edu.

Name	Phone Number	E-mail Address
SBCCD District Site	Date Last on Site	Last Day Physically Worked (in-person or remote)

Date of the Initial Positive Result	Date of Onset of Symptoms
First and Last Name of Immediate Supervisor	**What is your relationship with SBCCD? (check all that apply)** ☐ I am a student ☐ I am an employee ☐ Other ____________

Please List All Symptoms You are Experiencing (check all that apply):
☐ Fever ☐ Congestion or runny nose ☐ Headache ☐ Nausea or vomiting ☐ Cough ☐ Fatigue
☐ Shortness of breath or difficulty breathing ☐ Chills ☐ Body aches ☐ Sore throat ☐ Loss of smell ☐ Loss of taste

If you were on site within 24 hours of testing positive, please list the first and last name of each individual you were in close contact with. A close contact is defined as being near an individual for a cumulative total of 15 minutes or more over a 24-hour period during the COVID-19 case's infectious period.

If you were on site within 24 hours of testing positive, please list all buildings and departments you visited for a cumulative total of 15 minutes or more.

I certify that the information included on this form is true and accurate to the best of my knowledge.

______________________ ______________________

Signature Date