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| --- | --- | --- | --- | --- |
| **Location ID (assigned by Health Department** | **Address** | **City** | **Zip Code** | **County** |
|  |  |  |  |  |
| **Structure accessible for survey?** 🞏 Yes 🞏 No |
| **Primary Location Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # Eligible for survey†: \_\_\_\_\_\_\_\_** |
| **Survey Conducted in:** 🞏 English 🞏 Spanish 🞏 Haitian Creole 🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| No. | **Coworker Demographics** | **Date/Time of Interview** | **Symptoms during Period of Interest (see above) and Onset Dates (if known)** | **Travel (within 2 weeks before symptom onset, if coworker symptomatic, or within past 3 months if asymptomatic)** | **Date/Time of Specimen Collection** |
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| 03 | Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: 🞏 F 🞏 MDOB: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_Pregnant: 🞏 Yes 🞏 No 🞏 N/A 🞏 Unknown If Yes: Due date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ or LMP: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_ or Gestational age: \_\_\_\_\_\_\_wks |  \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_:\_\_\_\_\_ 🞏AM 🞏PM🞏 Consent declined🞏 Ineligible  | Fever 🞏 Yes 🞏 No Onset date: **\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_**Rash 🞏 Yes 🞏 No Onset date: **\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_**Conjunctivitis (red eyes) 🞏 Yes 🞏 No Onset date: **\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_**Joint pain (not from injury) 🞏 Yes 🞏 No Onset date: **\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_**Seen at a hospital or clinic for symptoms? 🞏 Yes 🞏 No  | 🞏 Yes 🞏 No If Yes: Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dates of travel:**\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_** to **\_\_\_\_/\_\_\_\_/\_\_\_\_\_**Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dates of travel:**\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_** to **\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_** | Urine\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_:\_\_\_\_\_ 🞏AM 🞏PMSerum\_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_:\_\_\_\_\_ 🞏AM 🞏PM🞏 Consent declined🞏 Ineligible |
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