Employee COVID-19 Screening Tool

Date: _____

Employee Name	Before Starting Shift				After Completing Shift				Additional Notes
	Temp	Cough	Shortness of Breath	Other Symptoms	Temp	Cough	Shortness of Breath	Other Symptoms	

Legal Disclaimer: This form is for sample purposes only. Consult with your attorney and your professional liability carrier to ensure that all of the dental practice's informed consent forms comply with state law. ***(This document should be customized for your office.)***

Keating Dental Lab 16881 Hale Avenue, Irvine, CA 92606 **T**: 949.955.2100 **W**: keatingdentallab.com