Department of Corrections
WASHINGTON STATE

COVID-19 SCREENING WORKPLACE DENIAL FORM

Please complete this form immediately and provide it to your supervisor/designee prior to leaving your work location.

Name: _____ Date: _____ Time: _____

Position: _____ Supervisor: _____

Work schedule: _____ Work location/unit: _____

Last date physically at work: _____ Telephone number(s): _____

Please include the contact number you may be reached at

I am not being allowed entry into the workplace for the following reason(s) with the associated screening question number(s)*****.

#	Reason for denied entry	Initial	#	Reason for denied entry	Initial
___	_____	_____	___	_____	_____
___	_____	_____	___	_____	_____

You are required to contact the secondary screening nurse identified below for your facility/office location today before the end of your scheduled work shift to arrange a phone appointment to assess your ability to return to work.

If you fail to call the secondary screener prior to the end of your scheduled work shift on the day you are denied entry, you will be placed on your own leave or unauthorized leave without pay in accordance with the applicable leave laws or collective bargaining agreement.

AHCC & WCCW (360) 480-3936	CBCC & WSP (360) 810-1973	CCCC, MCCCW & SCCC (360) 999-3673	CRCC & Satellite offices (360) 480-3936
LCC & CCD (360) 764-0259	MCC & OCC (360) 810-1722	WCC & Work Release (509) 710-8297	

If you reach the secondary screener's voicemail, you must leave a clear message to include your full name, position, date, time of call, assigned work location, valid phone number(s), and a timeframe you will be available to receive a call back. You are required to answer all calls at the designated number during the timeframe you indicated in the voicemail. The secondary screener nurse will return the call within 48-hours.

Your signature below acknowledges that you understand your responsibilities as outlined above. Additionally, you're acknowledging you potentially have a contagious disease, or were exposed to someone who has, and coming to work would jeopardize the health of others. ***(Provide employee a blank form, when unable to copy prior to leaving worksite)***

_____	_____	_____
Employee Name	Signature	Date
_____	_____	_____
Active screener/supervisor Name	Signature	Date

Supervisor/designee: Did employee call in related to being denied access due to screening? ☐ Yes ☐ No

If **YES**, read the employee's responsibilities over phone and confirm their understanding. Make sure this form is completed and entered into the Secondary Screening SharePoint site by your designated contributor. Send a blank copy of the form via email to employee and indicate "via phone" on signature line above. Ensure the form is routed to Human Resources for retention.

Secondary screening is the process used after an employee is denied entry to the workplace due to COVID-19 active screening process.

Active Screening: *Experienced a **NEW** cough; sore throat; loss of taste or smell; shortness of breath; muscle aches; fever with a temp at or above 100.4 or sense of fever; nausea, vomiting, diarrhea, or congestion **OR** *within the last 14-days, have you had close contact without the use of appropriate PPE with someone who is currently sick with suspected or confirmed COVID-19? *If Health Care Providers, refer to language regarding healthcare workers authorized by the HQ Emergency Operations Center. **OR** have you traveled outside of the country to a region where the new SARS-CoV-2 variant has been widely circulating, including but not limited to the United Kingdom, South Africa, or Brazil?* **Reference:** Covid-19 Active Screening Questionnaire

The contents of this document may be eligible for public disclosure. Social Security Numbers are considered confidential information and will be redacted in the event of such a request. This form is governed by Executive Order 16-01, RCW 42.56, and RCW 40.14.

Distribution: **ORIGINAL** - Employee Occupational Health Record