***COVID19 form for all CBU workers (employee, green badge contractor or Business Partner)***

***with suspected signs and symptoms on a Chevron work site***

***How to use this form***

***For CBU employee workers complete Section A:***

1. ***notify the worker’s CBU supervisor, consult*** ***with 811 and report to the Enterprise Health Representative*** [***Nnenna.Okoro@chevron.com***](mailto:Nnenna.Okoro@chevron.com) ***(1-713-372-5901).***
2. ***submit Section A without the worker’s name and position to*** [***Chevron Health & Medical***](mailto:CBUMED@chevron.com)***.***

***For green badge workers complete Section A:***

1. ***notify the worker’s company supervisor, CBU supervisor, consult with 811 and report to the Enterprise Health Representative*** [***Nnenna.Okoro@chevron.com***](mailto:Nnenna.Okoro@chevron.com) ***(1-713-372-5901).***
2. ***submit Section A without the worker’s name and position to*** [***Chevron Health & Medical***](mailto:CBUMED@chevron.com)***.***

***For Chevron Business Partner workers complete Sections A & B:***

1. ***notify the worker’s Business Partner supervisor and CBU supervisor.***
2. ***submit completed form without the workers name and position to*** [***Chevron Health & Medical***](mailto:CBUMED@chevron.com)***.***
3. ***medic or their designate is to maintain the original form for 30 days.***

***Section A***

|  |  |
| --- | --- |
| Date and Time of the event: | Work Site Location: |
| Worker’s Company: | Worker’s Name and Position: |
| Worker’s Supervisor: | Chevron Supervisor: |
| Person Completing Form: | |

***Section B***

|  |  |  |
| --- | --- | --- |
|  | **YES** | **NO** |
| Did the Worker immediately self-isolate on recognition of symptoms? |  |  |
| On-Site medic was contacted by radio or cell and assessed using the COVID-19 protocol? |  |  |
| Was the Chevron Supervisor contacted? |  |  |
| Was the Worker’s Supervisor contacted? |  |  |
| Was the Worker requested to contact 811 and speak to Provincial Health Authority? |  |  |
| How long has Worker been experiencing the symptoms? | | |
| How many days has worker been on shift? | | |
| Have the Worker’s close-contacts been identified and recorded? |  |  |
| Is the worker and its close-contacts names on the sign-in sheet? |  |  |
| Are the sign-in sheets secured and stored for a minimum of 30 days? |  |  |
| Where are the sign-in sheets located? | | |
| Was the Worker informed of the return to work protocol? |  |  |
| **Notes:** | | |
|  | | |
|  | | |
| ***This form is to be kept with the secured sign-in sheets once distributed*** | | |