# Workers Name Form

| Worker name: ____________________________ | DOB (mm/dd/yyyy): __ / __ / _____ |
| Organization: __________________________________________ | US destination state: _____________ |
| Facility name, location: __________________________________________________________________ | |
| Dates worked (mm/dd/yyyy): __ / __ / _____ to   __ / __ / _____ | Staff role: _________________________ |
| Duties: _________________________________________________________________________________ | |

I certify that I completed this form and the information provided below is accurate to the best of my knowledge.

Worker signature: ____________________________  Date: ____________

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## EXPOSURE ASSESSMENT

(To be completed by worker after the last work shift and reviewed by organization’s Medical Supervisor. Questions apply to past 21 days.)

Complete the “Known or Potential Exposures” section below if you answer YES to any question in this section.

**For all workers in non-ETU (Ebola treatment unit) settings:** Had unprotected* exposure to any of the following?

- An acutely ill person later diagnosed with Ebola or the person’s body fluids
  - YES
  - NO
- A person who died of Ebola-compatible illness** but not confirmed as having Ebola or the person’s body fluids
  - YES
  - NO
- The body of person who died of Ebola or Ebola-compatible illness or unknown cause
  - YES
  - NO

**For workers who did not do clinical or laboratory work, this section is complete.**

**For health care workers in non-ETU health care facilities:**

- Provided clinical care to an acutely ill patient later diagnosed with Ebola?
  - YES
  - NO
- Provided clinical care to a patient who died of Ebola-compatible illness** but not confirmed as having Ebola?
  - YES
  - NO

**For laboratory workers in non-ETU settings who handled or processed patient specimens:**

- Processed lab specimens of a patient later diagnosed with Ebola?
  - YES
  - NO
- Processed specimens of patient who died of Ebola-compatible illness* but not confirmed as having Ebola?
  - YES
  - NO

*Unprotected means without use of recommended personal protective equipment (PPE).

**Ebola-compatible illness includes body temperature ≥100.4°F or 38°C or subjective fever, or signs/symptoms including severe headache, fatigue, muscle pain, vomiting, diarrhea, abdominal pain, or unexplained hemorrhage.
### Known or Potential Exposures (Complete this section if answered YES to any question above.)

**Date of incident:** __ / __ / ______

**Location of incident:** ________________________________________________________________

**Type of exposure:**
- [ ] Needlestick or other sharps injury
- [ ] Splash to mucous membrane (eye/nose/mouth)
- [ ] Direct exposure to skin
- [ ] In close proximity (3 feet / 1 meter) while not using PPE
- [ ] Other (specify): ________________________________________________________________

**PPE worn during incident:**
- [ ] none
- [ ] gloves
- [ ] gown
- [ ] face mask
- [ ] respirator
- [ ] face shield
- [ ] eye protection

**Describe incident:**
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**Action taken:**
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

**Reviewed by:**

**Name:** _______________________________  **Title:** _______________________________

**Organization:** _______________________________________________________

**Signature:** ___________________________________   **Date:** _________________

END OF EXPOSURE ASSESSMENT
**HEALTH ASSESSMENT (To be completed by Medical Supervisor within 24-48 hours of worker’s departure)**

<table>
<thead>
<tr>
<th>Worker name: ____________________________</th>
<th>DOB (mm/dd/yyyy): __ / __ / _____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date assessment completed: _____________</td>
<td>Time: ________________</td>
</tr>
<tr>
<td>Name of person performing the assessment: ___________________</td>
<td>Title: ___________________</td>
</tr>
<tr>
<td>Signature: ________________________________________________________________________</td>
<td></td>
</tr>
</tbody>
</table>

**Ebola vaccination status**

<table>
<thead>
<tr>
<th>Ebola vaccine received:</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
</table>

If vaccinated, specify:  
- Primary prevention
- Post-exposure

Date of vaccination: __ / __ / _____

Name of vaccine: ________________________________  Lot no._____________  Expiration: ___ / ___ / ____

**Clinical assessment**

Appears well:  
- YES
- NO, specify: ____________________________________________

Oral temperature measurement: ____________ °F / °C

**Signs and symptoms in past 48 hours, medication history**

<table>
<thead>
<tr>
<th>Signs/symptoms:</th>
<th>None reported</th>
<th>Fever – if yes, specify:</th>
<th>Not measured (subjective)</th>
</tr>
</thead>
</table>

Highest temp measured: _______ °F / °C  Method: _____________  Date: __ / __ / _____  Time: ______

- Fatigue
- Weakness
- Muscle pain
- Vomiting
- Diarrhea
- Abdominal pain
- Headache
- Joint pain
- Sore throat
- Difficulty breathing
- Chest pain
- Unexplained bruising/bleeding

Earliest symptom onset: Date: __ / __ / _____  Time: ______

Use of antipyretic medication(s) in past 12 hours:  
- None

Name of antipyretic: ___________________  Dose: _______  Time: _______  Purpose: _____________

Name of antipyretic: ___________________  Dose: _______  Time: _______  Purpose: _____________

Was malaria prophylaxis taken as prescribed:  
- YES
- NO

Name of antimalarial: ____________________________

END OF HEALTH ASSESSMENT