**CITY OF SAINT PAUL**

**EMPLOYEE’S COVID-19 SAFETY REPORT**  **COVID WC CLAIM ADDENDUM 01/2022**

EMPLOYEES WHO WISH TO MAKE A CLAIM FOR WORKERS COMPENSATION BENEFITS ALLEGING THAT THEY CONTRACTED COVID-19 IN THE COURSE AND SCOPE OF THEIR WORK DUTIES MUST SUBMIT THIS COVID WC CLAIM ADDENDUM WITH THE “EMPLOYEE’S SAFETY REPORT” WITHIN 24 HOURS OF A POSITIVE COVID-19 TEST RESULT.

**DEPARTMENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DIVISION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ACTIVITY CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **First Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Middle Name or Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Last Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Telephone: Home** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Cell** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **State \_\_\_\_Zip \_\_\_\_\_\_**
4. **Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_** **Pronouns** He/Him/His [ ]  She/Her/Hers [ ]  They/Them/Their [ ]
5. **COSP Employee Number** \_\_\_\_\_\_\_\_\_ **Marital Status** Married [ ]  Divorced [ ]  Single [ ]
6. **Last four digits of social security number** \_\_\_\_\_
7. **Job Title** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Salary** $\_\_\_\_\_\_\_ **Per Hour** [ ]  **Annually** [ ]

**COVID -19 INJURY INFORMATION**

1. **Date of COVID-19 test** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Where was the test done?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Type of test taken?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **What was the result of the test?** Positive [ ]  Negative [ ]  Unknown [ ]
4. **When did you first develop symptoms of COVID-19?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **How long after your symptoms developed did you receive a positive test result?**
6. **Have you received additional medical treatment?** Yes [ ]  No [ ]  **If yes,** **ER or Urgent Care** [ ]  **Clinic** [ ] **Hospital** [ ]
7. **Provide name and address of physician and/or hospital:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
8. **For the two weeks prior to your symptoms or positive COVID-19 test, where was your City worksite? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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1. **Does your job require visiting other City worksites?** Yes [ ]  No [ ]  **If yes, please list all City worksites visited, and the dates for the two weeks prior to your symptoms or positive COVID-19 test.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Does your job require you to work with the public?** Yes [ ] No [ ]  **If yes, describe the work you do and the safety measures at your worksite**. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Have you been notified in the two weeks prior to your COVID-19 positive test that you were named by a fellow employee who had tested positive for COVID as someone who had been in close contact with that employee?** Yes [ ]  No [ ]   **If yes, which employee and when?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **List the names of all persons who live in your home, whether full or part-time.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **Do any of the persons that live in your home work or go to school outside the home?** Yes [ ]  No [ ]
2. **Have any of those persons been told in the month prior to the time you tested positive that they had been exposed to COVID-19?** Yes [ ]  No [ ]  **If yes, what were the dates of the exposure(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
3. **Has anyone in your household tested positive for COVID-19 in the last month?** Yes [ ]  No [ ]  **If yes, when?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. **Has anyone who has been to your home in the last month developed COVID symptoms or tested positive for COVID?** Yes [ ]  No [ ]  **If yes, list the date and their symptoms.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. **What places have you been to in the two weeks prior to developing symptoms or testing positive for COVID? (Include stores, places of worship, friend or family homes, recreation places, places to eat).** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. **What precautions to COVID do you take in public?** Wear a Mask all the time [ ]  Wear a Mask Indoors Only [ ]  Wear a Mask unless eating or drinking [ ]  Wear a Mask Only when required [ ]  Never wear a Mask [ ]  Use other Personal Protective Equipment (provde details) [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Briefly state why you believe your COVID was contracted through work rather than another source? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**I certify that all statements in this report are true** YES [ ]  No [ ]   **Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Employee Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Supervisor’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEPT AND SPVRS SHOULD KEEP A COPY OF THE COMPLETED FORMS BEFORE SENDING THEM TO WORKERS COMPENSATION DEPARTMENT VIA FAX: 651/266-8886 OR EMAIL:** **WorkersCompensation@ci.stpaul.mn.us**