**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** Choose an item. **DIVISION** Click or tap here to enter text. **ACTIVITY CODE** Click or tap here to enter text.

1. **First Name** Click or tap here to enter text. **Middle Name or Initial** Click or tap here to enter text. **Last Name** Click or tap here to enter text.\_
2. **Telephone: Home** Click or tap here to enter text. **Work** Click or tap here to enter text.**Cell** Click or tap here to enter text.
3. **Street Address** Click or tap here to enter text.  **City** Click or tap here to enter text. **State** Click or tap here to enter text.**Zip** Click or tap here to enter text.
4. **Date of Birth** Click or tap here to enter text. **Pronouns** Choose an item.**Marital Status** Choose an item.
5. **COSP Employee Number** Click or tap here to enter text.
6. **Last four digits of social security number** Click or tap here to enter text.
7. **Job Title** Click or tap here to enter text.\_ **Salary** $ **Per Hour  Annually**

**COVID -19 INJURY INFORMATION**

1. **Date of COVID-19 test** Click or tap to enter a date.
2. **Where was the test done?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Type of test taken?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **What was the result of the test?** Choose an item.
4. **When did you first develop symptoms of COVID-19?** Click or tap to enter a date.
5. **How long after your symptoms developed did you receive a positive test result?** Click or tap here to enter text.
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:** Click or tap here to enter text.
8. **For the two weeks prior to your symptoms or positive COVID-19 test, where was your City worksite?** Choose an item.
9. **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.** Click or tap here to enter text.
10. **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**.Click or tap here to enter text.
11. **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? If yes, which employee and when?** Click or tap here to enter text.
12. **List the names of all persons who live in your home, whether full or part-time.** Click or tap here to enter text.
13. **Do any of the persons that live in your home work or go to school outside the home?** Yes  No
14. **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)** Click or tap here to enter text.
15. **Has anyone in your household tested positive for COVID-19 in the last month?** Yes  No  **If yes, when?** Click or tap to enter a date.
16. **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.** Click or tap here to enter text.
17. **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).** Click or tap here to enter text.
18. **What precautions to COVID do you take in public?** Choose an item.
19. **Briefly state why you believe your COVID was contracted through work rather than another source?** Click or tap here to enter text.

**I certify that all statements in this report are true** Click or tap here to enter text. **Date** Click or tap to enter a date.

**(Employee Signature)**

**Supervisor’s Name** Click or tap here to enter text. **Date** Click or tap to enter a 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**](mailto:WorkersCompensation@ci.stpaul.mn.us)