Department of Corrections
WASHINGTON STATE

COVID-19 SCREENING WORKPLACE DENIAL

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 best contact number to reach you

Return to Work (RTW) Phase (1, 2, or 3): _____ **RTW date**: _____

I am being denied entry into the workplace for the following reason(s) with the associated screening question number(s)*****. **The RTW date is calculated using the applicable flyer** – Refer to current Phase for guidance.

Ques #	Reason for denied entry per WA DOC COVID-19 Active/Passive Screening Questionnaire* applicable Phase
_____	_____
_____	_____

If close contact exposure, indicate type of contact: ☐ work/community ☐ ongoing household

NOTE: Under COVID-19 Staffing Shortage Return to Work (RTW) Guidance Phase 2 and Phase 3, your facility/worksite will provide your RTW date based on the reason for denied entry. You **DO NOT** need to call the secondary screener. If necessary, the nurse will contact you based on the clinical guidelines. You're expected to answer your phone or return any message from the nurse within a 24-hour period. It is important to answer your phone even if from an unidentified number. Your RTW protocol may also include Rapid Antigen Testing and strict mask adherence. You're expected to review and adhere to the RTW Guidance flyer as outlined based on the phase your facility/worksite.

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 under the applicable phase over the phone and confirm their understanding. Make sure this form is completed and sent to the facility/site SL2S distribution list below for entry into the Department Outbreak Tracing System (DOTS) by your designated contributor. Send a blank copy of the form and flyer via email to the employee and indicate "via phone" on signature line above. Ensure the denial form is routed to the local Human Resources office for retention.

Reference: WA DOC COVID-19 Active/Passive Screening Questionnaire*

SL2S distribution list:

AHCC: DOCDLAHCCSL2S@DOC1.WA.GOV
CBCC: DOCDLCBCCSL2S@DOC1.WA.GOV
CCCC: DOCDLCCCCSL2S@DOC1.WA.GOV
CRCC: DOCDLCRCCSL2S@DOC1.WA.GOV
LCC: DOCDLLCCSL2S@DOC1.WA.GOV
MCC: DOCDLMCCSL2S@DOC1.WA.GOV
MCCCW: DOCDLMCCCWSL2S@DOC1.WA.GOV
OCC: DOCDLOCCSL2S@DOC1.WA.GOV
SCCC: DOCDLSCCCSL2S@DOC1.WA.GOV
WCC: DOCDLWCCSL2S@DOC1.WA.GOV
WCCW: DOCDLWCCWSL2S@DOC1.WA.GOV
WSP: DOCDLWSPSL2S@DOC1.WA.GOV
Reentry Centers: DOCDLWRSL2S@DOC1.WA.GOV
CCD offices: DOCDLCCDSL2S@DOC1.WA.GOV
Satellite offices: DOCDLAODL2SL@DOC1.WA.GOV

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