MCPHC/MCHD COVID-19 CASE REPORTING FORM

Date of Report_____ Business Reporting_____

Supervisor Reporting_____ Phone_____

Name of Reported Case_____ DOB_____ Phone_____

Address_____County_____

Parent/Guardian Name (if minor) _____ Phone_____

Worker's Job Title_____ Job Duties_____

Specific location and/or area worked_____

Date tested_____ Testing Facility_____ Copy of test obtained? Y N

Date of Symptom Onset_____ Last Date in Attendance_____

CLOSE CONTACTS (at business or associated functions)

Name	DOB	Relationship	Date Last Exposed	Phone#	Notified of Quarantine?

When complete, please fax to MCPHC at (812)-353-3135 or email to publichealthnurse@iuhealth.org. Thank you.