

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?
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This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and extend across the width of the page. There is no handwriting or other markings on the paper.

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