# **Staff Questionnaire**

**Where possible this questionnaire should be completed in correspondence with Line Managers**

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| **Infectious Disease Questionnaire - Positive COVID test result** | | | |
| **STAFF NAME** |  | **U NUMBER** |  |
| **CONTACT DETAILS** | **Confirm best/easiest way to contact:** | | |
| **SCHOOL/DEPARTMENT** |  | | |
| **ARE YOU IN A STUDENT FACING ROLE?** |  | | |
| **TEST RESULT** | **DATE** | | |
| **PCR** |  | | |
| **LFD** |  | | |
| **ARE YOU SYMPTOMATIC?** *(If so what date did your symptoms start)* |  | | |
| **HAVE YOU RECEIVED A COVID-19 VACCINATION? (Y/N/Date)** | ***You are under no obligation to answer this question, however this will be helpful from a business planning perspective*** | | |
| **1st Dose** |  | | |
| **2nd Dose (if applicable)** |  | | |
| **Booster** |  | | |
| **HAVE YOU ATTENDED CAMPUS IN THE 48 HR PERIOD PRIOR TO DEVELOPING SYMPTOMS OR TESTING (IF ASYMPTOMATIC)?** | ***If yes,******provide dates and locations below*** | | |
| **No** |  | | |
| **Yes** | *Dates/Location(s)* | | |

THE CONTENT OF THIS FORM SHOULD BE SENT BY THE **SMT REPRESENTATIVE ONLY** TO [STUDENTWELLBEING@TEES.AC.UK](mailto:STUDENTWELLBEING@TEES.AC.UK)