



Reset Form

# OCCUPATIONAL MEDICAL SERVICES (OMS) COVID-19 Department Reporting Form

## To Be Completed by Departmental COVID-19 POC If An Employee:

- 1) Is exposed to an individual who is being tested for COVID-19 or has tested positive for COVID-19.  
or
- 2) Is themselves quarantined, is being tested for COVID-19 or has tested positive for COVID-19.

Please return the form to OMS via fax 240-777-5132 or email at [medicalinfo.oms@montgomerycountymd.gov](mailto:medicalinfo.oms@montgomerycountymd.gov) along with supporting documentation (if received) within 24 hours of notification/exposure.

Date of Symptoms or Exposure: \_\_\_\_\_ Department: \_\_\_\_\_

1. Did this contact or exposure occur at work?  Yes  No

2. Employee's last name: \_\_\_\_\_ Employee's first name: \_\_\_\_\_

3. Employee's Oracle ID Number: \_\_\_\_\_

4. Personal and work email addresses of affected employee: \_\_\_\_\_  
\_\_\_\_\_

5. Cell phone number of affected employee: \_\_\_\_\_

6. Supervisor of affected employee: \_\_\_\_\_

7. Department COVID-19 Point of Contact: \_\_\_\_\_

8. Which of the following is the employee reporting? **Select One Option**      Please List Names of Other Employees  
 (HCP = Healthcare provider, PHO = Public Health Official)      Who May Have Been Exposed  
 (Name & Contact Information)

- Positive COVID-19 test for self
- COVID-19 tested, awaiting results
- Sick at home, PHO ordered to quarantine & contact HCP
- Sick at home, HCP ordered quarantine, no COVID-19 test
- Positive COVID-19 test for household member
- Suspected COVID-19 exposure at work
- Suspected COVID-19 exposure elsewhere

9. Last Date of Affected Employee's Attended Work: \_\_\_\_\_

10. Expected Return to Work Date: \_\_\_\_\_ Actual Return to Work Date: \_\_\_\_\_

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