



Washington Township

Fire Department

Special Order **V6.0** –

Corresponds with Operational Period 5

Topic: Coronavirus Disease 2019 (COVID-19)	Effective Date:	03/12/2020
	Revised Date	4/15/2020

The care, treatment, and transportation of persons suspected of infectious diseases is evolving on nearly a daily basis. Information from Public Health – Dayton and Montgomery County that has been developed in conjunction with the Greater Miami Valley EMS Council and Region 3 Regional Physicians Advisory Board. It is required that you read, understand, and practice the procedures and concepts put forth. None of this information should be foreign to you as this information models procedures already learned during exposure control training. However, if you have any questions or concerns, contact the on-duty shift commander. Here is a link for additional information from the CDC concerning COVID-19 <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>.

All members should develop/continue good infectious disease prevention practices:

- To help prevent infections, keep your hands away from your eyes, nose, and mouth.
- All members follow the CDC’s five step, 20-second method of proper hand washing: Wet, Lather, Scrub, Rinse and Dry.
- Use hand sanitizer if handwashing is unavailable.
- Cover your mouth with a tissue or sleeve when sneezing or coughing.
- Wipe down “high-touch” surfaces and items daily.

Prework Screening Procedures

- Members will be screened prior to the start of each shift as well as crew members who are off-going. The following section will outline this process. Any questions should be referred to the on-duty battalion chief immediately.
- **Prior to members entering the building for the start of their shift, they shall don their cloth face masks in preparation for interacting with one another for pre/post-work screenings. (Refer to special order for specifics of face mask use)**
- Members will only enter into each station through a single door:
 - Station 41 – C-side apparatus bay man door
 - Station 42 – A/D corner apparatus bay man door
 - Station 43 – A/B corner apparatus bay man door
 - Station 44 – B/C corner apparatus bay man door
 - Station 45 – C-side apparatus bay man door
 - HQ – C-side training room entry door

- Members will NOT enter into living quarters prior to screening
- Both on-coming and off-going members will be screened (temperature taken, S&S assessed) by a lieutenant or member riding in-charge upon arrival and before going in-service, as well as prior to leaving for the off-going crew members.
 - If a lieutenant or in-charge member is not present due to an emergency dispatch, members should self-monitor and document appropriately.
- Per CDC guidelines, members will be screened for the following daily:
 - COVID-19-like symptoms (**a new cough or a change in a chronic cough, or difficulty breathing/shortness of breath**)
 - **Temperature >100.4°F with a department provided temporal scanner**
 - **If yes to any of the above, deny entry into the station**
- Please remember that seasonal allergies and chronic respiratory issues (i.e. smoker's cough, sneezing, runny nose, etc.) are not alone related to COVID-19.
- Member's vitals and/or symptoms will NOT be recorded; however, members who are screened will have their name recorded by the person in-charge on the COVID-19_Screening_Log (can be found on the intranet). These logs will be collected daily by the on-duty battalion chief and forwarded to Deputy Chief Emmons.
- Asymptomatic members will be in-service immediately after the screening process has been completed. Symptomatic members, showing signs of **ANY** of the above listed symptoms, will be denied entry into the station, removed from service by the lieutenant/person riding in-charge and the on-duty battalion chief should be notified immediately to make final decision on their duty status. The member should not be permitted into the living quarters and will be placed on sick time in CrewSense.
 - Members will return to work when symptoms have resolved for at least 72 hours AND seven (7) days from the onset of symptoms.
 - Members who display signs and symptoms while at home or work should **NOT** wait to be instructed by the department to pursue assessment and treatment from their primary care physician. Once a care plan has been created for them by their primary care physician they should notify the department of their prognosis and orders.
 - If a member, off-going or oncoming, screens for COVID-19-like symptoms, proper decon should begin immediately. Retrace the member's path of travel and decon all items touched.
- Off-going members will complete the screening process and leave the station. If an off-going member is symptomatic for COVID-19-like symptoms (see above), they should report this to their supervisor and they should **NOT** report to work until their symptoms have met the criteria outlined above (72 hours' w/o symptoms and 7 days from onset). They should also seek guidance from their primary care physician immediately.
- If someone must enter the station outside of 0600 shift-change (e.g. 1800 shift-change for OT or part-time), they must be screened prior to entering living quarters in the same manner outlined above.
- Off-duty members are not permitted in the stations or HQ without prior approval from the on-duty battalion chief and notification of their arrival. An exception to this is a member picking up their gear prior to the start of their shift. If this is required, the member should call first and attempt to have an on-duty member bring their gear outside to them. If they must enter the station, they should be screened prior to entering.
 - Off-duty members are not permitted to work out in the station weight rooms.

PPE

Exposure Level	Patient Status	Appropriate PPE			
		Mask	Gloves	Goggles	Gown
High Risk	Temp >100.4F, COVID-19-like symptoms (a new cough or a change in a chronic cough, or difficulty breathing/shortness of breath); OR the use of aerosol-generating procedures (CPAP, nebulizer, etc.); OR travel to a geographic area with known COVID-19 or interaction with COVID-19 exposed person.	N95*	Yes	Yes	Yes
Medium Risk	Any other EMS-related incident	N95*	Yes	Yes	No
Low Risk		N95*	Yes	Yes	No

*N95 masks usage and disposal will follow the guidelines outlined in this document's section and the associated Battalle instructions for collection and decontamination.

- IMPORTANT: PPE conservation must begin immediately.** To conserve PPE currently in-stock, as directed by ODH and CDC, crews should remember to send a **single person** in to assess the patient on calls for service involving a request for medical aid. The single member who is assessing the patient shall have all appropriate PPE donned prior to exiting the apparatus cab, and all other members **SHOULD NOT** don PPE until advised to do so by the member providing care to the patient, this includes your gloves. To reiterate, the conservation of PPE is everyone's responsibility and any preservation now will make a difference going into the future.
 - The member making initial contact and any other members operating as a primary or secondary patient care provider shall don their PPE (N95, glasses, gloves) regardless of whether the patient is suspected of COVID-19. A suspicion of COVID-19-like illness should only heighten your senses with regards to donning a gown and/or Tyvek suit.
 - Although lift-assist calls are not necessarily medical in nature, there is an increased likelihood that a person requesting a lift assist may also be ill. These calls are close-contact and could easily transfer the virus from the patient to a responder. For this reason, appropriate PPE precautions (gloves, glasses, N95) should be taken and worn during lift-assist calls as well.
 - If the patient is known to be critical prior to making contact, all members providing care should don the appropriate PPE, but use your best judgement on the number of members who are initially used. We want all members to be safe; however, our ability to procure PPE is limited, like all other departments in the United States. Once our PPE is gone, it will take time to replenish and we want to prevent the unnecessary use in the meantime.
- If an engine/ladder first responds and is required to make first contact with the patient, the single point of contact guidelines should continue to be followed. If the patient requires greater care than what the single engine/ladder crew member is capable of providing, the number of caregivers may increase to the appropriate number (two (2) or

three (3) depending on circumstances. Doing so will reduce unnecessary PPE usage as we as limit exposure to the lowest number of providers.

- When responding to all emergency incidents, whether the dispatched information is related to COVID-19 or not, members should consider the patient to be on the “risk” spectrum. Patients who do not present with COVID-19-like symptoms will fall into the low-risk category. Patients exhibiting signs and symptoms of COVID-19 will fall into the medium- and high-risk categories, depending on treatments provided and exposure potential.
- When patients do not have a mask on, members should utilize their N95, gloves, and eye protection at a minimum, and have the patient place a surgical mask on themselves. If they are unable to place the mask themselves, the member should assist.
- PPE use should be limited to those who will potentially be interacting with the patient. If you are part of an engine crew remaining outside of the structure, you should **NOT** immediately don your facemask and gown, unless otherwise instructed by the medic crew based on patient status.
- N-95 respirators have been fit-tested and training on donning, wearing, and doffing PPE has been provided through FR1 and/or in-person.
- Drivers, if they provide direct patient care (e.g., moving patients onto stretchers), should wear all recommended PPE. After completing patient care and before entering an isolated driver’s compartment, the driver should perform hand hygiene with gloves on, remove and dispose of PPE and perform hand hygiene with gloves off to avoid soiling the compartment.
- Drivers should remember to engage the fans in the box and ensure that it is not on recirculate. The fans are most effective with the side-window closed per the manufacturer.
- If the transport vehicle does **not** have an isolated driver’s compartment, the driver should perform hand hygiene with gloves on, remove the face shield or goggles, gown and gloves and perform hand hygiene with gloves off.
- If a suspected COVID-19 patient is able to walk to the medic, then we should encourage this practice.
- All medic units should have Visqueen/crash wrap applied to the pass-through or the window between the box and the cab to minimize or eliminate the potential for contamination of the cab and subsequently the driver.
- All medic units will have crash wrap applied to the box cabinets to help minimize or prevent potential contamination, and to help with the decon process after COVID-19 related calls for service.
 - Essential items will be placed in Ziploc bags and placed outside of the cabinets for quick access. Bags will remain sealed unless their contents are used, which will allow for easier decontamination procedures.
 - The sealing of the cabinets and Ziploc bags in no way prohibits members from accessing and using their contents.
 - Should you have to open a cabinet, that cabinet’s interior compartment should be fully decontaminated after the call, if dictated by the incident type.
- Do not let family members travel in the ambulance, unless there are extreme circumstances requiring them to accompany the patient. They could be infected.
- We have established a new N95 decontamination process with to our contract with Battelle and the associated N95 labeling requirements. However, the on-duty battalion

chief(s) will continue to inspect members' masks during rounds for immediate exchanges.

- In conjunction with our Battelle contract, members will:
 - Place their masks in the collection box at the end of their shift if the mask was worn during **any direct patient contact** during that shift (e.g. primary or secondary patient caregiver, performing the assessment prior to the medic crew arriving, riding in the box of the medic during transport). If you do not make direct contact, your mask should be retained and stored in between shifts in the issued paper bag as instructed previously.
 - Place their mask in the collection box if it is used during a high-risk procedure or with a high-risk patient (Resuscitation, Aerosol Generating Procedure, COVID-19 positive patient, etc.).
 - Continue to use their mask if it was not used during one of the examples above until the mask meets one or both of the criteria.
- It is imperative that members do not interact with patients unnecessarily. If fire crews and/or members of three-person units are capable of standing by unless requested by primary patient caregivers, they should. This will assist in PPE retention considerably.
- Members should refer to the “COVID-19 Public Service General Investigation V3” special order for guidelines on proper PPE usage while conducting public service type calls (e.g. smoke detector checks, CO calls).
- Members should refer to the “Social Distancing and General Use Face Masks” special order for guidelines on when they must use their cloth face mask and associated information.
 - Preference should be given to working out individually, using proper precautions and manageable weight in the absence of a spotter. No more than two members should use the weight room at one time if unable to work out individually. If two members occupy the weight room at any given time, cloth face mask shall be worn.

Clinical Aspects:

- Dispatch Centers should not announce on the air anything that indicates a patient has a disease. Instead, they could use terms such as “respiratory protection is indicated.”
 - If the dispatch information does not indicate the patient is in critical condition, engine crews should remain outside the structure and the second care provider from the medic unit should limit contact with the patient during the assessment and removal, if walking the patient out is viable.
- Use the “one person only, starting 6-feet away from the patient” as the routine approach to any infectious disease or dangerous patient and conduct a doorway triage.
 - During the doorway triage, if the patient is not already wearing a surgical mask, the single care provider should pass them a mask to don.
 - Conduct doorway triage by asking: “Does anyone here have a fever, cough, shortness of breath, or respiratory distress?” and “Has anyone here had previous contact with someone told they had a lab positive COVID-19 test?” (A “yes” to these questions OR if entering a facility with a confirmed COVID-19 patient OR entering an elevated risk community setting such as skilled nursing facility, managed care home, independent living facility, etc. is a trigger point to don a gown.)

- Reinforce we are here to help and need to take some universal precautions. The first being that we are going to pass you a mask and you need to put it on.
- Second, to keep everyone as healthy as possible, we are going to remain at a distance and ask our standard patient health history questions until an ambulance crew arrives to assume further patient care.
- When contacting a stable patient, fire apparatus crew members need not obtain vitals or perform other routine patient assessments. However, if the patient is unstable they should follow standing order protocols.
- When responding to in-district nursing homes and skilled care facilities, be aware that many have reduced their points-of-entry to a single entrance. Be prepared to complete a screening process that may consist of signing-in, having a no-touch temperature scan, and answering questions regarding your recent health. Please comply with their processes and report any issues to Battalion Chief Guadagno and your on-duty BC.
- Patient assessments:
 - Local health departments, in consultation with clinicians, determine whether a patient is a person under investigation (PUI) for COVID-2019. EMS providers should treat as a potential COVID-19 patient anyone who presents with:
 - Fever **or** signs/symptoms of respiratory illness (e.g. cough or shortness of breath)
 - And has, in the past 14 days, traveled to an area from an affected geographic region **or** any known exposure to a patient known or suspected to have COVID-19 infection.
 - Affected geographic areas with widespread or sustained community transmission are changing on a daily basis and travel history should NOT be the primary criteria for assessment.
- Notify the receiving hospital as early as possible. Expect to receive directions regarding which entrance to use.
 - Many hospitals have instituted screening processes that are conducted during the notification call. These processes often involve questions pertaining to the patient's status, signs and symptoms, and information about their travel and contact history.
- When using a nasal cannula on the patient, a surgical mask should be placed over top of the nasal cannula. Non-rebreather (NRB) use should be limited to patients with severe respiratory distress and in turn those patients should be treated as high-risk patients. This is because of the irritation that an NRB may cause to the respiratory tract resulting in coughing.
- Avoid aerosol-generating procedures (intubation, nebulizer, CPAP, etc.) in all patients and specifically when COVID-19 is suspected. If they must be utilized, do the procedure in an open-air location, not in a small room, or the back of the ambulance. A caveat to this guidance is that if the patient requires the treatment as a life-saving measure.
- Minimize the amount of EMS equipment in the care of the patient, and in the patient compartment to minimize contamination and the need for disinfection.
- Family members and other contacts of patients with possible COVID-19 should **not** ride in the transport vehicle, if possible. If riding in the transport vehicle, they should wear a facemask.
- Both MCSO and CPD will no longer be first responding into the home or for earlier patient contact to incidents involving suspected COVID-19 patients. They will however, continue to respond and remain outside the structure in case they are needed by on-scene

crews. The officers from both jurisdictions have been provided the appropriate PPE in case they are required to enter prior to our arrival (e.g. cardiac arrest).

ePCR documentation guidelines

Thorough documentation allows the department to accurately track member exposure and PPE usage. This data is helpful when forecasting for run volume increases, how much PPE is actually being used, and when to order additional PPE. When documenting an incident where you cared for and/or transported a with suspected COVID-19, in addition to normal documentation procedures, please make sure your ePCR notes the following:

- Everyone who interacted with the patient (engine crew, battalion, medic crew, etc.) should be documented in the ePCR's "crew info" tab under the "CAD info/Dispatch" tab.
- In the narrative, the author should document which providers came within the 6-foot radius of the patient, who the single care provider initially was, when the mask was placed on the patient, and what PPE was worn by the crew members.
- If you are assigned to a 3-person medic unit (M43/M44) and the second care provider is not needed for patient care, they should ride in the cab with the driver. This should also be documented accordingly in the ePCR.
- You may see different fields appear in your ePCR as we fine tune the reporting software. Please complete thoroughly and remember that the quality of your documentation impacts our ability to track and forecast, so please be diligent.

Cleaning and disinfecting apparatus

- After transporting the patient, leave the rear doors of the transport vehicle open to allow for sufficient air changes to remove potentially infectious particles.
- The time to complete transfer of the patient to the receiving facility and complete all documentation should provide sufficient air changes.
- When cleaning the vehicle, EMS providers should wear a disposable gown and gloves. A face shield or facemask and goggles should also be worn if splashes or sprays during cleaning are anticipated.
- Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly, to include the provision of adequate ventilation when chemicals are in use. Doors should remain open when cleaning the vehicle. Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2.
- Products with EPA-approved emerging viral pathogens claims are recommended for use against SARS-CoV-2.
- All surfaces that may have come in contact with the patient or materials contaminated during patient care (e.g., stretcher, rails, control panels, floors, walls, work surfaces) should be thoroughly cleaned and disinfected. Any and all horizontal surfaces should be cleaned.
- Clean and disinfect reusable patient-care equipment before use on another patient, according to manufacturer's instructions.
- Follow standard operating procedures for the containment and disposal of used PPE and regulated medical waste.
- Follow standard operating procedures for containing and laundering used linen. Avoid shaking the linen.

- Be diligent in cleaning the engines, ladder, and other staff vehicles as well as the medic units.
- During transport, equipment such as the LP15, laptop computer, cell phone and other unnecessary equipment should be placed in a compartment or secured in the front cab.
- At no time, should the primary provider use the laptop or cell phone while providing care to a suspected COVID-19 patient. The driver or member of another crew should provide the hospital notification.

Cleaning and disinfecting stations

A general cleaning of the building should be focused on the bathroom, kitchen, sleeping quarters, and day area of the building.

- Routine cleaning and disinfection procedures (e.g., using an EPA-registered, disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for influenza strands including COVID-19 in healthcare settings. This would focus on the horizontal surfaces in the kitchen, bathroom, sleeping quarters, and day areas of the station.
- Refer to [List Nexternal icon](#) on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against COVID. That list is attached.
- Clean and disinfect the building in accordance with standard operating procedures. All surfaces that may have come in contact with the crew should be thoroughly cleaned and disinfected using an EPA-registered disinfectant in accordance with the product label.
- Follow standard operating procedures for containing and laundering used linens. Avoid shaking the linen.
- Kitchenware should be cleaned using standard process
- Follow standard operating procedures for the containment and disposal of used PPE by the cleaning crew, and remove all garbage from the building.
- Fresh air ventilation of the building and living areas, if possible, should remove the remnants of any disinfection process.
- All stations will be professionally sanitized once per week. This occurs on Tuesday afternoons into the evening, beginning at 1530 at HQ. The station order for sanitization will remain constant and in the event that a crew is out of the station, the company will contact the BC for entry. BCs will be their point-of-contact on Tuesdays at 1530 at HQ.
- Members should clean weight rooms before and after use with appropriate disinfectant products.

Cleaning and disinfecting equipment

- If a member's SCBA (mask, mask-mounted regulator (MMR), pack) becomes exposed to a suspected COVID-19 patient due to interaction on a non-medical call (e.g. MVC, AFA), members shall disinfect those components consistent with the "COVID-19 Regulator and Face Piece Cleaning" special order.
- ****Reminder**** Member's must clean their MMRs at the beginning of each shift. Details on this process are located in the special order referred to above.

Follow-up and reporting by our members after caring for a suspected COVID-19 patient

- Members will follow the [Exposure Control Plan](#) guidance (can be found on the 'Fire Department Share (S:)' drive → EMS → Exposure Control Plan)

- After patient transfer is concluded, following the GDAHA & GMVEMSC Infectious Disease Exposure Reporting Policy page 149 <https://gmvemsc.org/uploads/protocol/2020PMtrainingmanual.pdf> by notifying the charge nurse in the ED, your on-duty battalion chief, as well as the infection control officer (Battalion Chief Guadagno) of your potential exposure.
- EMS documentation should include a listing of EMS clinicians and public safety providers involved in the response and level of contact with the patient (for example, no contact with patient, provided direct patient care). This documentation may need to be shared with local public health authorities.
- The member filling out the ePCR must click the COVID-19 box, which opens up an associated worksheet where pertinent information will be obtained for record keeping and tracking purposes.
- Download, complete, and email a copy of your “COVID-19_Member Statement,” which can be found on the intranet, to Deputy Chief Emmons for tracking purposes.

Follow-up to a true exposure and quarantine procedure(s)

- In the event that a member is involved in a **potential** exposure (e.g. contact with a high-risk patient, within the 6-foot bubble, unprotected, and exposed to airborne particulate through coughing, sneezing, etc. for greater than two minutes. **This timeframe includes up to 48 hours before the patient became symptomatic.**), they should:
 - Immediately inform their crew members who may not have been exposed, while remaining outside of the 6-foot distance from unexposed crew members.
 - Ensure they **don** a mask to prevent exposing additional crew members.
 - Notify the on-duty battalion chief as soon as possible.
 - Inform the charge nurse upon arrival to the hospital of the exposure.
 - Follow the GMVEMSC protocol for exposure reporting
 - **Members will no longer be removed from service due to an exposure per CDC guidelines.**
 - Fill out the department BWC paperwork, found on the intranet, and submit to their battalion chief.
 - Fill out and email a copy of the “COVID-19_Member Statement,” which can be found on the intranet, to Deputy Chief Emmons for tracking purposes.
- **Once the on-duty battalion chief has been notified, he will contact a deputy chief or the fire chief for notification purposes.**
- **Department members who have had an exposure but remain asymptomatic should adhere to the following practices:**
 - **Regularly monitor their symptoms, including their temperature, throughout their shift. They should evaluate their temperature at least two times per day.**
 - **Wear a mask at ALL TIMES while at work. This excludes while the member is in a private bunk, shower, or any other isolated instance; however, as soon as the member plans to exit isolation they must don a mask.**
 - **Continually practice social distancing.**
 - **Clean and disinfect all work spaces they come into contact with during the shift.**

- If the member begins to show **ANY** signs and symptoms during their shift, they will be relieved of duty and sent home immediately. Areas where they came into contact should be cleaned and disinfected immediately by on-duty crew. Co-workers with close contact within the 6' bubble should also consider themselves exposed.
- Information on each co-worker the member came into contact with that shift and for 48 hours prior should be compiled by the on-duty battalion chief and immediately forwarded to Deputy Chief Emmons.
- Once a member has been sent home, or does not report to work, due to exhibiting signs and symptoms consistent with COVID-19, they will not return to work until symptoms have resolved for at least 72 hours AND seven (7) days from the onset of symptoms.
- Most members will quarantine within their own homes, per CDC guidelines. However, if a member has a person(s) of the high-risk category at home (e.g. immunosuppressed family member, family member >65 y/o), there will be an option for fire department facilitated quarantine. This request needs to be communicated to a chief officer as soon as possible post-exposure.
- **While in home-quarantine, members should self-isolate from other individuals in the home.**
- A chief officer will contact ODH and/or Public Health to report the circumstances for further information and guidance on treatment directly from them to the member.
- **If signs and symptoms develop while off-duty: contact the on-duty battalion chief and report these circumstances, pursue treatment as you normally would from your primary care physician, and isolate from other members of the household. The isolation and exclusion from work period remains at 72-hours symptom-free and seven (7) days of onset.**

Exposure risk

Low Risk: Any member responding to a respiratory infection or unknown/suspected COVID-19 patient call who dons appropriate PPE prior to contacting the patient, are considered low risk.

Medium Risk: Any member who has prolonged close contact with patients with COVID-19 who were wearing a facemask while HCP nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Some low-risk exposures are considered medium-risk depending on the type of care activity performed (e.g. a member who is wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol-generating procedure) would be considered to have a medium-risk exposure.

High Risk: Any members who are not wearing PPE when they encounter an ill respiratory patient, known or unknown for COVID-19 status is considered a high risk exposure.

In all instances, members will remain on-duty and continue with normal job responsibilities. However, they should continue to indicate that this patient was suspected of COVID-19-like illness on their ePCR by checking the appropriate box and follow all other provisions for reporting contained within this document. Members who are involved in a medium or high risk exposure should self-monitor daily for fever or any COVID-19-like symptoms. If symptoms develop, stop work, isolate at home, notify a chief officer, and the chief officer will notify Public Health.

Conclusion

The most up to date information has been included in this Special Order-COVID-19 Exposure Control. Updated information may be obtained through the CDC, Ohio.gov, Dayton MMRS, Public Health of Dayton and Montgomery County, GDAHA and the GMVEMSC. With future steps in development, members will be apprised of any additional information disseminated by this collaborative, the CDC, local health officials or by Washington Township.

Our number one goal is your safety and ensuring quality information both to and from each member. As we receive additional, pertinent information, further versions of this document will be released to assist in our efforts. Please remember to document on your ePCR and additional document (e.g. COVID-19_member statement) as descriptive but concise as possible. The quality of your documentation will directly impact our ability to track exposures and pass on information to the appropriate entities.

Self-Monitoring/Screening Positive Symptoms

