THE QUEEN'S HEALTH SYSTEM UNIVERSAL COVID-19 RISK ASSESSMENT FORM (URAF)

Required (1 Or More Days) Before Return/Arrival to Facility for all persons:

1. Complete Universal COVID-19 Risk Assessment Form (URAF):
   sections A,B, and C for QHS employee
   sections A,B,C and D for Vendors/Contractors/Consultants)/Course Coordinator
   sections A,B,C and E for Students/Shadowers

Additionally required (3 Or More Days) Before Arrival to Facility for Vendors/Contractors/Consultants:

2. Account Registration in RepTrax/Intellicentrics Credentialing (intellicentrics.com)
3. Attach Any Available COVID-19 Test Result (please note QHS does NOT accept saliva based tests for clearance) and proof of COVID-19 vaccination(s).
4. If swabbing was not obtained prior to arrival and a limited exemption is needed, please email requests to QMCCOVIDexemption@queens.org

A. General Information (please complete all requested information)

Last Name:	First Name:
Phone#:	Email:
Employee Number (if QHS Employee):	Department Manager (If QHS Employee):

B. Health Assessment (please complete all requested information)

(for vendors/contractors/consultants/visitors/students/shadowers and RTW for QHS Employees)

In the past 10 days, have you come in close contact with a suspected or confirmed COVID-19 individual? Yes ☐ No ☐
Please explain:

In the past 10 days have you been living with an individual who is under quarantine? Yes ☐ No ☐
Please explain:

Do you have any of following signs and symptoms? (check all that apply)

Fever: Measured temperature_____	☐ Chills	☐ Abdominal pain
☐ Cough	☐ Headache	☐ Vomiting or Diarrhea
☐ Sore throat	☐ Muscle aches	Other, Specify_____
☐ Shortness of breath	☐ Loss of Smell or Taste	☐ None

Have you had a recent COVID-19 test? ☐ No ☐ Date of test: Result: Detected ☐ Not Detected ☐
Yes Type: Swab ☐ Saliva* ☐

**Please note QHS does not accept home/saliva based tests*

Have you received COVID-19 vaccination(s)? Yes ☐ No ☐

State vaccination(s) administered:

Date of vaccination #1: Date of vaccination #2: Date of vaccination #3/booster:

Date of vaccination #4/booster:

C. Travel History

For Hawaii residents, have you recently traveled out of the state in the last 10 days?	Yes ☐ No ☐
Anticipated Arrival Date to State: _____ **Date Leaving State (for non-residents):** _____	

D. Additional Required Vendor/Contractor/Consultant Information (please complete all requested information)	
Home Address:	Company:
Purpose of Visit:	Queen's Authorizing Sponsor/Contact #:
Anticipated Dates at Facility:	Areas/Departments Visiting:

E. Additional Required Student/Shadower Information (please complete all requested information)	
School/University:	Anticipated Dates at Facility (From-To):
Days/Hours:	Assigned Unit:
Name of Clinical Faculty:	Clinical Faculty Phone # (if available):

Please begin screening for temperature and any signs/symptoms twice daily 10 days prior to arrival at facility.

- For Employee RTW:
  - Please submit online URAF and await return to work confirmation via email.
- For New Hires:
  Please send copy of completed form and supporting documentation (i.e. vaccination card/swab results) to employeehealth@queens.org.
  Contact (808) 691-4533 for any questions.
- For travelers, students/shadowers, vendors/contractors:
  I attest that I am knowingly assuming the risk for potential exposure to COVID while at QHS. In the event of said exposure or positive COVID-19 test result after being on site at QHS, I understand that further investigation/contact tracing and COVID-19 testing/swabbing may be required.
  Signature: _____Date:_____
  Please send copy of completed forms to QMCCOVIDExemption@queens.org.