Current COVID-19 Guidance – last updated 6/16/2020

Vendor Screening Process

Initiated by Department who is requesting vendor services, prior to arrival to facility. Used for vendors who are to present to a SIH facility to repair or service a critical piece of equipment during COVID-19 Pandemic.

Directions: **Please notify Vendor that symptom screening will be completed on arrival and that if any symptoms present, Vendor will not be allowed into facility**

- Vendor will be expected to wear a mask while in facility
- Requesting department completes the top section of form prior to Vendor arrival
- Vendor is notified to call requesting department upon arrival to facility (prior to entering)

- Manager/Asst Manager/Supervisor/Biomedical Engineer Tech will meet Vendor at the employee entrance
- When called that Vendor is on site, instruct Vendor to employee entrance, bring this form, remainder of screening completed at employee entrance
- Form is completed on day of initial presentation

For consecutive days of service, instruct vendor to present to employee screening each day

Prior to Arrival

Vendor Company: _____

Vendor Representative Name: _____ _____
Last First

What department is equipment located: _____

Equipment to be repaired/serviced: _____

What makes this critical or urgent? _____

Upon Initial Arrival (Symptom Screening):

- ☐ Cough or shortness of breath, new or worsening in the last 7 days
- ☐ Vomiting or diarrhea in the last 48 hours
- ☐ Fever or 100°F within the last 72 hours, with or without the use of medication
- ☐ Or at least TWO of the following symptoms, new in the last 7 days without explanation: sore throat, headache, loss of taste/smell, fatigue; muscle ache/pain; nausea; abdominal pain; chills; repeated shaking with chills; nasal congestion; runny nose
- ☐ Unprotected contact for more than 15 minutes and less than 6 feet, or direct contact with secretions, with a person confirmed positive for COVID-19 within the past 14 days

* If Vendor has any checks in the Symptom Screening, Vendor will not be allowed into facility *

_____ _____
Facility Rep Printed Name (First Last) Date/Time

SEND COMPLETED FORM TO CORINNA WARREN, INFECTION PREVENTION

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