**Line List – Residents Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| First and last name | DOB | Sex | Room No. | Ever had symptoms (Y/N) | Date of Onset | Duration of Illness | Fever (Record highest temp.) | Symptoms – see list ^ | Ever Hospitalized (Y/N) | Hospital admission date | Death (Date) | Were ANY COVID tests POSITIVE? (Y/N) | Collection date for 1st Positive specimen | Date of most recent COVID test specimen collection | Most recent COVID result \* | Flu testing (+ or -) | Notes/tests for other pathogens | Current status of cases \*\*(optional) | Dates and Results of additional COVID tests (optional) | COVID vaccine dose 1 (date) or N/A | COVID vaccine dose 2 (date) or N/A |
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^Fever (F);Cough (C); Sore Throat (ST); Shortness of breath (B), Runny Nose (R); Nasal Congestion (N); Chest Congestion (CC); Muscle Aches (MA); Chills (Ch), Loss of Taste/Smell (L); Headache (H), Vomiting (V); Diarrhea (D)

\*Positive (+); Negative (-); Pending (P)

\*\*Not cleared (NC) Transmission-Based Precautions, Released from Transmission-Based Precautions (R), Unknown (U), N/A

**Line List – Staff Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| First and last name | DOB | Sex | Job/unit | Last day at work | Ever had symptoms (Y/N) | Date of Onset | Duration of Illness | Fever (Record highest temp.) | Symptoms – see list \* | Ever Hospitalized (Y/N) | Hospital admission date | Death (Date) | Were ANY COVID tests POSITIVE? (Y/N) | Collection date for 1st Positive specimen | Date of most recent COVID test specimen collection | *Most recent COVID result \** | Flu testing (+ or -) | Notes/tests for other pathogens/  date returned to work | Current status of cases \*\*(optional) | Dates and Results of additional COVID tests (optional) | COVID vaccine dose 1 (date) or N/A | COVID vaccine dose 2 (date) or N/A |
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^Fever (F);Cough (C); Sore Throat (ST); Shortness of breath (B), Runny Nose (R); Nasal Congestion (N); Chest Congestion (CC); Muscle Aches (MA); Chills (Ch), Loss of Taste/Smell (L); Headache (H), Vomiting (V); Diarrhea (D)

\*Positive (+); Negative (-); Pending (P)

\*\*Not cleared (NC) Transmission-Based Precautions, Released from Transmission-Based Precautions (R), Unknown (U), N/A