**SARC COVID-19 VENDOR/PROVIDER STAFF FORM**

***TO BE COMPLETED IN WORD FORMAT AND E-MAILED TO THE SAN ANDREAS REGIONAL CENTER DESIGNATED SIR EMAIL ADDRESS***

**Send the COVID 19 Form to** **sirsanjose@sarc.org****.**

**Your assistance is needed and appreciated. The Department of Developmental Services (DDS) requests Vendors/ Providers (including Long Term Care Providers: ICF DD- H/N/CN) complete this information for staff/employees meeting the following criteria (please note new criteria for reporting as of May 22, 2020):**

 **1) Staff from a Vendored Work Site location testing POSITIVE for COVID-19.**

 **Written by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Written:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Vendor/Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vendor #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**All FIELDS ARE REQUIRED**

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| --- |
| 1. **Work Site Name:**
 |
| 1. **Work Site Address:**
 |
| 1. **Work Site Type:** [ ]  **ARF** [ ]  **ARFPSHN** [ ]  **CCF** [ ]  **CCH** [ ]  **COUNTY CHILD WELFARE PLACEMENT** [ ]  **DAY PROGRAM** [ ]  **EBSH** [ ]  **EARLY START SERVICE PROVIDER** [ ]  **FAMILY** [ ]  **FFA**

[ ]  **FHA** [ ]  **GROUP HOME** [ ]  **HOSPITAL** [ ]  **ICF** [ ]  **ICF/ CN** [ ]  **ICF/ DD-H** [ ]  **ICF/DD-N** [ ]  **ICF/DD** [ ]  **INDEPENDENT LIVING** [ ]  **IMD** [ ]  **OWN HOME** [ ]  **RCFE** [ ]  **RESPITE** [ ]  **SLS** [ ]  **SFH** [ ]  **SNF** [ ]  **SRF**  |
| **4. Date Tested:** | **5. Date of POSITIVE Results:**  |
| **6. Comments:**  |

6.05.20