**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**](mailto: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