# **COVID-19 Recordkeeping Report of Positive Employee**

Recordkeeping applies until February 3, 2026, in compliance with Cal-OSHA regulation 3205(j) (<https://www.dir.ca.gov/title8/3205.html>). Complete this sheet for any reported COVID case and save with related documents until Feb 2028.

If an employee believes they got COVID at the worksite, include this with the supervisor's report/5020 Form if the employee states they want to file a Workers’ Compensation claim.

Explain to the employee that you are required to gather information on reported positive cases in compliance with Cal-OSHA regulations.

Email the completed checklist to disabilityunit@sonoma-county.org

## Required Information:

[ ]  Positive Employee Name:

[ ]  Positive Employee Job Class:

[ ]  Positive Employee County ID number:

[ ]  Positive Employee Home Phone Number:

[ ]  Primary worksite address:

[ ]  Date positive employee was last at a County work site:

[ ]  Did the employee go to any other worksite:

[ ]  Date positive employee was tested or diagnosed:

[ ]  Date department was notified of the positive test results:

## ****If the employee wants to file a Workers’ Compensation claim:****

Does the employee want to file a Workers’ Compensation claim?

[ ]  Yes [ ]  No

**If yes,** complete a [Supervisors' Report of Injury Form](https://sonomacounty.ca.gov/Main%20County%20Site/General/Sonoma/Sample%20Dept/Sample%20Dept/Divisions%20and%20Sections/Disability%20Management/Services/Disability%20Leaves/_Documents/Supervisor%20Report%20of%20Occupational%20Injury_Illness_Exposure%20Form_5020.pdf) or complete the 5020 form through the Intercare online portal. Let the employee know they will need to submit medical evidence to support their claim (like a PCR test) along with a DWC-1 form if they want to file a claim. Please have them call Kaiser Occupational Health to discuss their COVID case with a medical professional at 707-566-5555.

[ ]  Include this checklist with the report. Email to disabilityunit@sonoma-county.org

Name, title, and phone number of employee completing this form**:**