

COVID-19 Positive Test Result Reporting Form



Point of Contact		
These are details for individual submitting the form, NOT the individual with a positive test result. THE INDIVIDUAL WITH POSITIVE TEST RESULT SHOULD NOT BE IDENTIFIED ON THIS FORM.		
*Name	*Phone Number	*Email Address
Firm Name		
Relationship to Individual with Positive COVID-19 Test Result		
Trade of Individual with Positive COVID-19 Test Result		
Affected Location(s) Information		
Location 1 Name		
Site Building Code	Date(s) Visited	
Classrooms Visited	Other Areas Visited	
Location 2 Name <i>(if needed)</i>		
Site Building Code	Date(s) Visited	
Classrooms Visited	Other Areas Visited	
If affected individual visited other locations, please indicate relevant details at the end of this form.		
Case Details for Individual with Positive COVID-19 Test Result		
NYC Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Resident Address		
*Experiencing symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No		
*Last time person was in building(s)		
*When did symptoms begin?		
*Date of positive test		
Do you have any documentation (Doctor's note, lab result, etc.)?		
Is this the first time the person has tested positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If no, first time/date they tested positive:		
Other Details (optional)		

Email completed form to NoticeofAccident@nycsca.org and call the Provider Access Line at (866) 692-3641.