Enrollment Questionnaire

INSTRUCTIONS:
This survey will take about 5-10 minutes to complete. If you have any questions, please contact [XXXXX] at [-XXXXXXXX] or email XXXXXX.
Thank you again for your time.

A. Demographics, SARS-CoV-2 history and vaccination history

A1. What is your age?

A2. Are you male or female?

A2a. If you are female:

Are you pregnant?: (If yes, specify trimester)

Are you Breastfeeding?:

A3. What is your height in cm?

A4. What is your weight in kg?

A5. Have you ever been diagnosed with any of the following?

- ☐ Cancer
- ☐ Chronic Heart Disease, excluding high blood pressure
- ☐ High blood pressure/Hypertension
- ☐ Chronic Kidney Disease
- ☐ Chronic Liver Disease (such as cirrhosis, hepatitis, fatty liver disease)
- ☐ Chronic Lung Disease (such as asthma, COPD, bronchitis, etc…)
- ☐ Diabetes
- ☐ Immunocompromised, including solid organ transplant and HIV
- ☐ Neurological Disease, including cerebrovascular disease, epilepsy, multiple sclerosis, etc…
- ☐ Obesity
- ☐ Autoimmune disorder

A6. Do you currently smoke?

- ☐ Yes
- ☐ No

A6a: If no, have you smoked previously?

- ☐ Yes
- ☐ No

A7. How many people (not including yourself) do you live with?

- ☐ 0
- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6 or more

A8. Since January 2020, have you ever received a positive laboratory test for SARS-CoV-2, the virus that causes COVID-19?

- ☐ Yes
- ☐ No

A8a. If yes, when was the positive test (date), and what kind of test was performed (PCR or rapid test or serology)

- ☐ PCR (nasal swab)
- ☐ Rapid Test (nasal swab)
- ☐ Serology Test (a blood test)
- ☐ Don't remember

Date of Test _____

(Allow option for multiple positive test results)

COVID 19 Vaccination Questions

A9. When the COVID -19 vaccine becomes available, what are the chances that you will choose to receive a COVID-19 vaccination if you are offered one?

- ☐ Almost Zero Chance
- ☐ Very Small Chance
- ☐ Small
- ☐ Moderate
- ☐ Large
- ☐ Very Large Chance

☐ Almost Certain
☐ I have already received a COVID-19 vaccine: Date: _____

Vaccination history **COVID vaccine**	
1. Do you have a contraindication for the COVID-19 vaccine?	☐ Yes ☐ No ☐ Unknown
2. Have you received the first dose of any COVID-19 vaccine?	☐ Yes ☐ No ☐ Unknown
3. If yes, what was the date of the first dose? (dd/mm/yyyy)	___/___/___
4. Which vaccine did you receive? (product name)	
5. Mode of vaccine ascertainment (to be the verified by study staff)	☐ = vaccination card ☐ = vaccination registry ☐ = self-report ☐ = other (specify_____) ☐ = not documented
6. What was the Batch of the vaccine received?	Please provide the match number from the above documents or state ☐ Unknown
7. Have you received a second dose of the COVID-19 vaccine?	☐ Yes ☐ No ☐ Unknown
8. If yes, what day did you receive the second dose (dd/mm/yyyy)	___/___/___
9. Which kind of vaccine did you receive for the second dose (product name)	
10. What was the Batch number of the second dose vaccine you received?	Please provide the match number from the ascertainment documents or state ☐ Unknown
11. Mode of vaccine ascertainment of the second dose (to be verified by study staff)	☐ = vaccination card ☐ = vaccination registry ☐ = self-report ☐ = other (specify_____)

	☐ = not documented

Did you receive the influenza vaccine in the past winter (since September 2020)?

☐ Yes
☐ No

B. Occupation and Work Responsibilities

B1. In what departments, wards, or parts of your health facility do you regularly work? Check all that apply.

☐ Hospital
☐ Emergency Department
☐ Critical Care or Intensive Care Unit
☐ Infectious Diseases
☐ Lung diseases
☐ Internal Medicine and/or Medical Specialties
☐ Pediatrics and/or Pediatric Specialties
☐ Surgery and/or Surgical Specialties
☐ Gynecology and/or Obstetrics
☐ Oncology and/or Hematology
☐ Dentistry
☐ Radiology
☐ Outpatient clinic
☐ Pharmacy
☐ Laboratory
☐ Nutrition
☐ Social Assistance
☐ Physiotherapy
☐ Occupational therapy
☐ *Other*

B1a:_Other department or ward, please SPECIFY: _____

B2. What is your current job/occupation at the hospital?

☐ Nurse
☐ Medical doctor
☐ Midwife

- ☐ Laboratory technician
- ☐ Biologist
- ☐ Pharmacist
- ☐ Janitorial staff
- ☐ Food worker
- ☐ Social Worker
- ☐ Radiology Technician
- ☐ *Other*

B3. With which groups of patients do you have regular or daily face-to-face contact? Check all that apply.

- ☐ Infants aged <1 year
- ☐ Children aged 1-12 years
- ☐ Teenagers aged 13-19
- ☐ Adults aged 20-64
- ☐ Older adults aged 65 and older
- ☐ Pregnant women

B4. Are you a clinical health worker (such as a doctor, nurse, or medical technician) who provides hands-on medical care to patients?

- ☐ Yes
- ☐ No

B4a. [If B4= "Yes"] Do you perform any of the following procedures regularly (on most workdays)? This means you do this task yourself (and not simply oversee). Check any or all that apply.

- ☐ Collect a respiratory specimen using a swab
- ☐ Collect a sputum specimen
- ☐ Administer medication using a nebulizer
- ☐ Apply nasal cannula (two pronged tube for nasal oxygen)
- ☐ Apply oxygen face mask
- ☐ Perform tracheal intubation
- ☐ Insert a nasogastric (feeding) tube
- ☐ Perform manual ventilation
- ☐ Apply mechanical ventilation

☐ Perform suction of fluids or secretions
☐ Perform chest physiotherapy (such as chest percussion)
☐ Perform bedside bronchoscopy

C. Health Status

C1. How would you describe your current health overall?

☐ Excellent
☐ Very Good
☐ Good
☐ Fair
☐ Poor

E. Questions about Illness, Vaccines, and Missing Work

E1. How much do you know about the Covid-19 vaccine?

☐ Nothing at all
☐ A little
☐ Some
☐ A lot
☐ A great deal

E2. COVID-19 vaccination is safe.

☐ Strongly agree
☐ Mildly agree
☐ Neutral
☐ Mildly disagree
☐ Strongly disagree

E3. If you are unable to or don't get a COVID-19 vaccination, what do you think your chance of getting the COVID-19 will be?

☐ Almost Zero Chance
☐ Very Small Chance
☐ Small
☐ Moderate
☐ Large
☐ Very Large Chance

E4. How effective do you think the COVID-19 vaccine is in preventing you from getting sick with COVID-19?

- ☐ Extremely effective
- ☐ Very effective
- ☐ Somewhat effective
- ☐ Not too effective
- ☐ Not at all effective

E5. If you get a COVID-19 vaccination, what do you think your chance of getting sick with COVID-19 will be this year…?

- ☐ Almost Zero Chance
- ☐ Very Small Chance
- ☐ Small Chance
- ☐ Moderate Chance
- ☐ Large Chance
- ☐ Very Large Chance

E6. If I get an COVID-19 vaccination, I will be less likely to miss work because of getting sick with COVID-19.

- ☐ Strongly agree
- ☐ Mildly agree
- ☐ Neutral
- ☐ Mildly disagree
- ☐ Strongly disagree

E7. Compared to your co-workers at your health facility, how favorable or unfavorable is your attitude toward COVID-19 vaccination?

- ☐ Extremely more favorable
- ☐ Much more favorable
- ☐ Slightly more favorable
- ☐ Average for co-workers at my facility
- ☐ Slightly less favorable
- ☐ Much less favorable
- ☐ Extremely less favorable

E8. If I don’t get a COVID-19 vaccination, I will regret it.

- ☐ Strongly agree

☐ Mildly agree
☐ Neutral
☐ Mildly disagree
☐ Strongly disagree

E9. How worried are you about getting sick with COVID-19 during the next 12 months?

☐ Extremely worried
☐ Very worried
☐ Moderately worried
☐ A little worried
☐ Not at all worried

E10. I get sick with influenza and other respiratory viruses more easily than other people my age.

☐ Strongly agree
☐ Mildly agree
☐ Neutral
☐ Mildly disagree
☐ Strongly disagree

E11. Employees at my healthcare facility are encouraged to go home if they have respiratory symptoms at work.

☐ Strongly agree
☐ Mildly agree
☐ Neutral
☐ Mildly disagree
☐ Strongly disagree

F. <u>Questions about life outside of work in the past 7 days</u>

F1. Outside of the healthcare setting/your workplace, have you been in close contact with a confirmed COVID-19 patient or a person with COVID-19 symptoms?	☐ Yes ☐ No ☐ Unknown
F2. How many times have you used public transportation besides a family car (public bus, train)?	☐ 0 ☐ 1-2 ☐ 3-5 ☐ 5-8 ☐ 9 or more
F3. How many times have you attended a social indoor social event or gathering with MORE than 10 people? (This includes activities such as attending church/other house of	☐ 0 ☐ 1-2 ☐ 3-5

worship, parties, weddings, and sporting events, or visiting a bar or restaurant).	☐ 5-8 ☐ 9 or more
F4. How often have you worn a mask when in an indoor setting outside of your home?	☐ always ☐ often ☐ sometimes ☐ rarely ☐ never ☐ did not go to indoor locations outside home
F5. How often have you stayed at least 2 metres from other people in indoor spaces outside your home?	☐ always ☐ often ☐ sometimes ☐ rarely ☐ never ☐ did not go to indoor locations outside home
F6. How many times have people who do not live in your household visited your home?	☐ always ☐ often ☐ sometimes ☐ rarely ☐ never
F7. How many times have you visited other people in their homes?	☐ always ☐ often ☐ sometimes ☐ rarely ☐ never ☐ did not go to indoor locations outside home

Recent Symptoms:

In the past (7) days, have you experienced any of the following symptoms (check all that apply):

- ☐ Fever
- ☐ Cough
- ☐ General Weakness
- ☐ Fatigue
- ☐ Headache
- ☐ Muscle aches
- ☐ Sore Throat
- ☐ Runny Nose
- ☐ Shortness of Breath
- ☐ Lack of Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Altered Mental Status
- ☐ Loss of Taste
- ☐ Loss of Smell

If yes to any of symptoms:

Date of onset of first symptom: _____

Did you see a doctor for your symptoms?

- ☐ Yes
- ☐ No

Did you go to an emergency room?

- ☐ Yes
- ☐ No

Did you get hospitalized for your symptoms?

- ☐ Yes
- ☐ No

Did you get tested for SARS-CoV-2?

- ☐ Yes
- ☐ No

If yes, what test was done, check all that apply:

- ☐ Rapid test (Nasal Swab)
- ☐ PCR (Nasal Swab)
- ☐ Blood test
- ☐ Xray or CT scan

What were the results?

- ☐ Covid-19 Positive
- ☐ Covid-19 Negative