Return to Work - For Use During the Covid-19 Pandemic Only

Employee Name: _____ Date: _____

Staff name/title reviewing form: _____

Complete questions below if you have been off work due to illness and are seeking to return to work:

1. Please indicate if you have had any of the following symptoms in the past fourteen days (check all that apply):

   ___ cough ___ fever ___ shortness of breath ___ sore throat ___ runny nose

2. If you had any of the above symptoms, have those symptoms improved? ___ yes ___ no

3. When was the approximate onset of your symptoms? Date: _____

4. Has it been at least seven days since the onset of your symptoms? ___ yes ___ no

5. Have you been without a fever for at least three days (72 hours) without the use of any medication? ___ yes ____ no

6. Did you seek treatment for your symptoms? ___ yes ___ no

7. If you sought treatment for your symptoms, please provide the date of your visit or hospitalization and the name of your provider. If your provider has given you a release to return to work please attach a copy to this form.

   Date of Visit/Treatment _____

   Physician or Hospital name/location_____

8. Have you been tested for COVID-19? ___ yes ___ no

9. Have you had direct unprotected (without PPE) contact with anyone who tested positive for COVID-19? ___ yes ___ no

10. If you have had direct unprotected contact with anyone who has tested positive for COVID-19, please describe the contact, provide the date of contact and state whether you self-isolated at home for 14 days after the contact?

    Date of Contact and description of contact: _____

    Dates of self-isolation: _____ ___ N/A

11. If you have been tested for COVID-19 and it was positive, were you able to get two consecutive FDA-approved COVID-19 tests done at least 24 hours apart with negative results (2 negative tests)? ___ yes ___ no ___ N/A

Employee Certification:

I, [print name]_____, by signing below, certify:

- **I have been without a fever for at least three days (72 hours) without the use of any medication, my symptoms have improved, and it has been at least seven days since my symptoms first appeared;**
- **To the best of my knowledge, I have not had direct unprotected (without PPE) contact with anyone positive for COVID-19 in the past 14 days;**
- **The information I have provided above is true and accurate to the best of my knowledge and belief.**

Signature of Employee: _____ Date: _____

Signature of Reviewer: _____ Date: _____