REGISHRG
EMPLOYER HR SOLUTIONS

RETURN TO WORKPLACE FORM (COVID-19)

If you have been absent from your workplace for self-isolation or quarantine reasons related to Covid-19, you must complete the following form based on the CDC guidelines to discontinue isolation in order to ensure you can return to the workplace. **Please make sure your responses are accurate as of the date listed.** You may fill out forms on other dates as circumstances change.

Employee Name: _____ Date: _____

1. Do you have any reason to believe that you <u>are</u> or <u>were</u> infected with COVID-19?
☐ YES *(if YES, was the diagnosis confirmed by a COVID-19 test: ☐ YES ☐ NO)*
☐ NO

2. Did you experience or are you experiencing any COVID-19 symptoms during self-isolation, such as fever, chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea, vomiting, or diarrhea?
☐ YES
☐ NO

If you answered NO to both Questions 1 & 2, Skip to Question 5. Otherwise, continue to Question 3.

3. If you answered YES to Question 1 due to a positive test result and NO to Question 2, have 10 days passed since your positive test?
☐ YES *(if YES, Skip to Question 5)*
☐ NO *(if NO, you should continue isolation)*
☐ N/A *(if this question is not applicable, continue to the next question)*

4. If you answered Yes to Question 2, answer the following questions:

Have at least 10 days passed since symptoms first appeared? ☐ YES ☐ NO
Have at least 24 hours passed where you have no fever (without the aid of fever-reducing medication)? ☐ YES ☐ NO
Have your symptoms improved? ☐ YES ☐ NO

If you answered YES to all the questions in 4 or this question is not applicable, continue to Question 5. If you answered NO to any of the questions in 4, you should continue isolation.

5. In the last 14 days, have you come into close personal contact (within 6 feet distance and for about 15 minutes or longer) with anyone exhibiting symptoms of COVID-19 or who has a laboratory confirmed COVID-19 diagnosis?
☐ YES *(if YES, you should continue isolation)*
☐ NO *(if NO, continue to the next question)*

6. Do you have a weakened immune system (immunocompromised) due to a health condition or medication or any other condition that may affect the length of your isolation?

☐ YES *(if YES, continue to the next question)*

☐ NO *(if NO, you may end your isolation and return to the workplace)*

7. If answered yes to Question 6, have you talked a healthcare provider and both you and the provider agreed that you may end your isolation and return to the workplace?

☐ YES *(if YES, you may end your isolation and return to the workplace)*

☐ NO *(if NO, you should continue isolation)*

The medical information you have provided is kept confidential as is practical and consistent with business necessity.

I certify that the statements in this form are true and complete as of the date of this form and understand that further information may be required.

_____ _____

Employee Signature **Date**