# Return to Work After COVID-19 Symptoms or Exposure Certification Form

You must complete this self-certification form prior to your return to work if you:

* Had symptoms of COVID-19;
* Have had close contact with an individual diagnosed or showing symptoms of COVID-19; or
* Been directed to self-isolate or quarantine by your health care provider or a public health official.

Once you have completed this form you must return the form to **[insert appropriate company representative or department]**. Any failure to properly and completely fill out this form may lead to your inability to return to work. Please direct any questions to **[insert appropriate company representative or department].**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that the following statements are true and accurate:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Statement** | **Yes** | **No** | **N/A** | **Comments** |
| It has been at least 24 hours since I have been free of a fever **[insert (100.4° F or higher) *or* (state definition of fever)]** without the use of fever-reducing medicines .and from other symptoms.\* |   |   |   |   |
| Any respiratory symptoms (cough and shortness of breath) have improved. |   |   |   |   |
| Any other symptoms (e.g., loss of taste or smell, gastrointestinal problems, such as nausea, diarrhea, and vomiting) have improved. |   |   |   |   |
| At least 10 days have passed since my COVID-19 symptoms first appeared |   |   |   |   |
| I have not been in close contact with anyone who has exhibited any COVID-19 symptoms in the past 14 days |   |   |   |   |
| I have not been in contact with anyone who has tested positive for COVID-19 |   |   |   |   |

Date respiratory symptoms began improving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (write N/A if no symptoms)

Date fever began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (write N/A if no fever)

Date symptoms began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (write N/A if no symptoms)

As defined by the CDC, the following counts as “close contact”:

* You were within 6 feet of someone who has COVID-19 for a total of 15 minutes or more;
* You provided care at home to someone who is sick with COVID-19;
* You had direct physical contact with the person (hugged or kissed them);
* You shared eating or drinking utensils; and/or
* They sneezed, coughed, or somehow got respiratory droplets on you.

I further certify that the above statements are true and correct.

Employee Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today's Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Returned to Work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This self-certification form will be treated as a confidential medical record in compliance with the Americans with Disabilities Act (ADA).