**COVID-19 Employee Self-Certification to Return to Work**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, attest to the following:

|  |  |
| --- | --- |
| Employee Initials |  |
|  | I have had no fever for at least three days without taking medication to reduce fever during that time.  |
|  | I have not experienced any respiratory symptoms (cough, shortness of breath, difficulty Breathing, chills, muscle pain, sore throat, new loss of taste or smell) or other known COVID-19 symptoms for at least three days (See attached CDC Flyer). |
|  | At least seven days have passed since my fever and/or respiratory symptoms began. |
|  | In the past 14 days, I have not been in contact with anyone who has exhibited one or more of the above symptoms. |

**BY SIGNING BELOW, I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE, AND THAT I VOLUNTARILY SIGNED THIS ACKNOWLEDGMENT.**

Employee name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today's date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date returned to work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

