Covid-19 Return To Work Form

To help prevent the spread of COVID-19 in the workplace, every worker must complete the following form before returning to work. Every question must be answered.

Employee Name:

Manager Name:

Name of workplace & Address:

Questions		Yes	No
1	Do you have symtoms of cough, fever high temperature, sore throat, runny nose, breathlessness or flu like symtoms now or in the past 14 days?		
2	Have you been diagnosed with confirmed or suspected COVID-19 in the past 14 days ?		
3	Are you in close contact with a person who is confirmed or suspected of having COVID-19 in the past 14 days?		
4	Have you been advised by a doctor to self-isolate at this time?		
5	Have you been advised by a doctor to cocoon at this time?		
6	Please provide details, not included above that may need to be considered to allow your safe return to work.		
Additional Information:			

If your situation changes after you complete and submit this form, please notify management immediately.

Print Name_____ Signature:_____ Date:_____