|  |  |  |  |
| --- | --- | --- | --- |
|  |  | |  |
| **[company name]**  **Employee Name:** |  | **Contact**  **Info:** | |
|  |  | |  |
|  | | | |
| **Employee Review Prior to Authorizing Return to Work during COVID-19 Pandemic** | | | |

Did EE exhibit COVID-19 symptoms during illness?

**YES** **NO**

Did EE seek medical help from a health care professional (HCP) during illness?

**YES** **NO**

Would illness normally require a medical release before rtn to work?

**YES** **NO**

Complete info below

Obtain medical release

Follow restrictions

**START HERE**

**Circle Response**

Was EE tested for COVID-19?

**YES** **NO**

Did EE test positive for COVID-19?

**YES** **NO**

Follow HCP restrictions

Complete info below

**Before returning to work, the EE should exhibit the following:**

1) Free from fever for 7 days (3 days

w/o use of fever reducing

medications).

2) ***AND*** improvement of respiratory

symptoms, including cough.

Did HCP place restrictions on EE before return to work?

**YES** **NO**

***COVID-19 / Related Symptom Illness***

***Non-COVID-19 Illness***

Approved Return to Work Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mgmt Approval: \_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*(Initials)*

Comments/Restrictions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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