Employee Self-Certification Form

Please note that [COMPANY] is relying on your honesty to maintain the health and safety of the workplace.

RETURN FROM CONFIRMED COVID-19 ILLNESS OR COVID-19 SYMPTOMS

If employee has not been tested for COVID-19:

I, ________________________________, certify that:

- I have not had a fever (100.4 F or higher) for at least 72 hours (that is without the use of fever-suppressing medicine); AND
- My symptoms, such as cough or shortness of breath, have improved; AND
- At least 10 days have passed since my symptoms first appeared.

If employee has been tested for COVID-19:

I, ________________________________, certify that:

- I have not had a fever (100.4 F or higher) for at least 72 hours (that is without the use of fever-suppressing medicine); AND
- My symptoms, such as cough or shortness of breath, have improved; AND
- I have received two negative tests in a row, 24 hours apart.

RETURN FROM QUARANTINE OR TRAVEL TO LEVEL 3 AREA

I, ________________________________, certify that I have not been ill with COVID-19 or experienced COVID-19-like symptoms, such as fever, cough, or shortness of breath, within the past 14 days.

Furthermore, I certify that within the past 14 days, I have not visited any Level 3 Travel Health Notice Countries. For a list of such countries: https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html.

Nor have I violated the April 3, 2020 travel.state.gov Global Level 4 Health Advisory https://travel.state.gov/content/travel/en/traveladvisories/ea/travel-advisory-alert-global-level-4-health-advisory-issue.html.
DISCLOSURE OF DOMESTIC TRAVEL
(LAST 14 DAYS)

In the last fourteen (14) days, from date of this executed document, I travelled to the following domestic locations (including counties outside of my county of residence).

1. __________________________  5. __________________________
2. __________________________  6. __________________________
3. __________________________  7. __________________________
4. __________________________  8. __________________________

RETURN FROM CARING FOR OR LIVING WITH AN INDIVIDUAL WHO HAS HAD CONFIRMED COVID-19 ILLNESS OR COVID-19 SYMPTOMS

I, ____________________________, certify that:

- It has been 14 days since I have cared for or been in close contact* with an individual who has had confirmed covid-19 illness or covid-19 symptoms, AND
- I have not been ill with COVID-19 or experienced COVID-19-like symptoms, such as fever, cough, or shortness of breath, within the past 14 days.

*Close contact is defined by the CDC as (a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case, or (b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on).

This policy is subject to change in accordance with any changes in circumstances or guidance from the CDC, public health officials, or government (federal, state, or local).

Employee Name (please print) ______________________________________________________

Employee Signature ____________________________________________________________

Date ____________________________________________________________

REVIEWED BY:

HR Name (please print) ______________________________________________________

HR Employee Signature ________________________________________________________Date_____________________

Disposition Status:

Cleared to Return to work Y / N Effective Date: __________________________

Reevaluate on ______________________

*: Completed form will be maintained in a confidential file, separate from your personnel file.