



## COVID-19 Employee Self-Certification to Return to the Workplace

This form must be completed for all employees returning to the workplace following site closure(s) and again anytime an individual experiences COVID-19 symptoms.

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

I have had no fever for at least three days without taking medication to reduce fever during that time.

Date of last fever of 100.4 degrees or higher: \_\_\_\_\_ (write N/A if no fever present)

My respiratory symptoms (cough and shortness of breath) have improved.

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

At least 10 days have passed since my fever and/or respiratory symptoms began.

Date fever and/or respiratory symptoms began: \_\_\_\_\_ (write N/A if no symptoms present)

I agree that if any information in this attestation changes, I will notify Human Resource immediately.

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

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

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

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



# Clarke Schools for Hearing and Speech

clarkeschools.org

**The following is provided for an employee's personal use to document his or her symptoms and recovery. This page should not be provided to the employer but kept for the employee's personal records.**

Date symptoms began: \_\_\_\_\_

Date of last fever of 100.4 degrees or higher: \_\_\_\_\_

Date respiratory symptoms began improving: \_\_\_\_\_

Date	Temperature	Respiratory symptoms? (Y/N)	Other symptoms or notes