

**COVID 19 – PRE-RETURN TO WORK FORM**

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| **Question** | **Yes** | **No** |
| Do you have symptoms of cough, fever, high temperature, sore throat, runny nose, breathlessness or flu like symptoms now or in the past 14 days? |  |  |
| Have you been diagnosed with confirmed or suspected COVID-19 infection in the last 14 days? |  |  |
| Are you a close contact of a person who is a confirmed or suspected case of COVID-19 in the past 14 days (i.e. less than 2m for more than 15 minutes accumulative in 1 day)? |  |  |
| Have you been advised by a doctor to self-isolate at this time? |  |  |
| Have you been advised by a doctor to cocoon at this time? |  |  |

I confirm that I have responded to the questions above truthfully based on my current condition.

I also commit to advising Line Management if this situation changes and I will exclude myself from my work location should I develop Covid-19 symptoms and seek GP advice while I self-isolate at home.

**NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYEE NO.:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMPLOYER:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_