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**Return to the Office: COVID-19 Employee/Contractor Self-Certification**

Effective [insert date]

I certify that the following is true (please check YES or NO in response to each question):

1. □ YES □ NO I am currently experiencing cough, shortness of breath, or difficulty breathing.

2. □ YES □ NO I am currently experiencing *at least two* of the following symptoms: fever, chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell.

3. □ YES □ NO I have been within six feet of someone diagnosed with COVID-19 for at least thirty minutes during the past fourteen (14) days.

4. □ YES □ NO I reside with someone who has been advised by a health care provider to self-quarantine or isolate due to COVID-19 symptoms.

5. □ YES □ NO I have experienced a fever or respiratory symptoms in the past fourteen (14) days. Ifanswered “**YES**,” answer follow-up questions below.

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

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

Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\*\*Only answer the following questions **if you answered “YES” to question 5** and have experienced a fever or respiratory symptoms in the past fourteen (14) days:

□ YES □ NO I have had no fever for at least three (3) days without taking medication to reduce fever during that time.

□ YES □ NO My respiratory symptoms (cough and shortness of breath) have improved for at least three (3) days.

Check here if no respiratory symptoms are or were present: □ N/A

□ YES □ NO At least seven (7) days have passed since my fever and/or respiratory symptoms began.