EFFECTIVE: 4/1/2020
This policy revokes and replaces all previous policies on this topic and will expire on 12/31/2020

COVID-19 RELATED ABSENCE – RETURN TO WORK CERTIFICATION

An employee absent due to COVID-19 Symptoms must present this form to the Treasurer / Collector prior to the day he/she returns to work. An employee may not work without submitting this form and receiving approval from the Town Administrator.

1. Employee Name: _____
2. Job Title: _____
3. If you have tested positive for COVID-19, please respond to the following:
   a. Provide the date on which your fever resolved without the use of fever-reducing medications:

      _____

   b. Provide the date on which you experienced an improvement in respiratory symptoms (e.g. cough, shortness of breath):

      _____

   c. Provide dates of two negative results of COVID-19 tests from at least two consecutive nasopharyngeal swab (nasal swab) specimens collected 24 hours apart:

      (1) _____

      (2) _____

      Attach copies of proof of the two negative results with this form.
4. If you have exhibited symptoms of COVID-19 but have **not received a positive test**, please respond to the following:
   a. Provide the date on which your symptoms first appeared:

      _____

   b. Provide the date your fever resolved without use of fever-reducing medications:

      _____

   c. Provide the date you experienced improvement in respiratory symptoms (e.g. cough, shortness of breath):

      _____

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d. Have at least three (3) days (72 hours) have passed since the later date of b and c above? Yes/No

NOTE: If "No," then you will not be permitted to return to work until 3 days/72 hours have passed from the later of the dates set forth in b and c above.

e. Have at least seven (7) days have passed since the date in a above? Yes/No
NOTE: If "No," then you will not be permitted to return to work until 7 days have passed since the date set forth in a above.

5. If you have been absent from work due to one of the following:

(-) You have been subject to a coronavirus quarantine or isolation order;

(-) You have been advised by a health care provider to self-quarantine due to coronavirus concerns; and/or

(-) You have been caring for an individual who has been subject to a or b above;

a. Provide the date on which you began to quarantine/isolate/care for someone in these circumstances:

_____

b. Has it been fourteen (14) days since the date you began to quarantine/isolate/care for someone in those circumstance? Yes/No

NOTE: If "No," then you will not be permitted to return to work until 14 days have passed since the date in (5a) above.

I hereby certify that the foregoing facts are true and correct, and that this form is executed under penalty of perjury at _____, this _____ day of _____, 2020.
(List City and State)

_____
Signature of Employee

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Check list for Reviewer:

If COVID Positive:

( ) two negative swab results collected 24 hours apart attached.

If presumptive case of COVID (i.e. no test):

( ) At least 3 days have passed since later of (4b) and (c) above.

( ) At least 7 days have passed since onset of symptoms in (4a) above.

Quarantine/Isolation/Care for Someone in Quarantine/Isolation:

( ) At least 14 days have passed since the start date.

Employee's Return to Work on: _____
(Date)

Approved by: _____
(Signature)

_____
(Title)