**COVID-19 Return to Work Form**

| To help prevent the spread of COVID-19 in the workplace, every individual must complete and sign this form before returning to work. While reviewing this form, management may try to contact you and ask you not to return to work immediately and will discuss a suitable future date for your return. N.B. every question must be answered |
| --- |

| Employee Name: | Manager Name: | | |
| --- | --- | --- | --- |
| Workplace Address: | | | |
| Questions | | Yes | No |
| 1. Do you have symptoms for cough, cold, high temperature, sore throat, runny nose, breathlessness, flu like symptoms, or loss or change to your sense of taste or smell now or in the past 14 days? | |  |  |
| 2. Have you been diagnosed with confirmed or suspected COVID-19 infection in the last 14 days? | |  |  |
| 3. 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 2 meters for more than 15 Minutes altogether in 1 day)? | |  |  |
| 4. Have you been advised by a doctor to self-isolate at this time? | |  |  |
| 5. Have you been advised by a doctor to cocoon at this time? | |  |  |
| 6. Please provide details\* below of any other circumstances relating to COVID-19, not included in the above, which may need to be considered to allow your safe return to work. Further information on people at higher risk from Coronavirus can be accessed [here](https://www2.hse.ie/conditions/covid19/people-at-higher-risk/overview/). | |  |  |
| Additional Information: | | | |

\* If you are not sure whether or not you are in an at-risk category, please check the link in Question 6. If your situation is changed after completing and submitting this form, please tell the management.

**Print Name: Date:**