

COVID-19 Return to Office Declaration

Employee Health and Safety Form

Full Name

Department

Date

Please confirm the following statements regarding your current health status and possible exposure to COVID-19 prior to re-entering the office.

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I am not currently experiencing any symptoms associated with COVID-19 (such as fever, cough, shortness of breath, new loss of taste or smell).

☐

I have not been in contact with anyone diagnosed with or suspected of having COVID-19 in the last 14 days.

☐

I have not tested positive for COVID-19 in the last 14 days.

☐

I have not traveled internationally or to a COVID-19 hotspot in the past 14 days.

Other comments (if any):

Signature

Date