Renfrew County and District Health Unit

"Optimal Health for All in Renfrew County and District

COVID-19 Attestation for Return to Work Following Illness

Please complete this form to confirm that you are healthy and able to return to work. **Check only one box**. By adding your signature, you are verifying that the information is true. Return the completed form to your workplace.

Employee's Name: ___________________________________

I was sent home or denied entry to my workplace because of one or more symptoms consistent with COVID-19 on ___________________ *(day/ month/ year)* **and can now return to work because:**

- ☐ My symptoms are not new and have not changed. I was previously seen by a doctor or nurse practitioner and was diagnosed with a chronic condition, such as allergies or asthma, with the exact same symptoms that I have now.
- ☐ I was assessed by a doctor or nurse practitioner since I was sent home or denied entry to work. The doctor or nurse practitioner told me that another diagnosis (medical reason) other than COVID-19 explains my symptoms and did not recommend that I be tested for COVID-19 at this time.
- ☐ I have received a negative COVID-19 test after starting to feel sick **AND** my symptoms have been improving for at least 24 hours (or 48 hours with vomiting or diarrhea) **AND** I have not had a fever in over 24 hours without medication.
- ☐ I chose not to be tested for COVID-19 and I have completed 10 days of self-isolation since my symptoms started.
- ☐ I have tested positive for COVID-19 and have completed the required self-isolation period determined by the Renfrew County and District Health Unit.

I was identified as a close contact of someone who tested positive for COVID-19 and:

- ☐ I have tested negative for COVID-19 and have completed 14 days of self-isolation.
- ☐ I have not been tested for COVID-19, but I have completed 14 days of self-isolation and I am well with no symptoms.

Date of COVID-19 test *(if applicable)*:____________________________________ *(day/ month/ year)*

I declare that I am well, and I am able to return to work.

Employee Signature:_____________________________Date:____________________ *(day/ month/ year)*