This form should to be completed and returned to your manager before returning to work.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Circle either Yes or No***

* 1. Do you have symptoms of cough, fever, high temperature, sore throat, runny nose, breathlessness or flu like symptoms now or in the past 14 days? Yes / No
  2. Have you been diagnosed with confirmed or suspected COVID-19 infection in the last 14 days? Yes / No
  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 2m for more than 15 minutes accumulative in 1 day)? Yes / No
  4. Have you been advised by a doctor to self-isolate at this time? Yes / No
  5. Have you been advised by a doctor to cocoon at this time? Yes / No

Is there any further information which you feel we should be aware of at this time?

Yes / No (*If Yes, please give details)*

I declare the above information to be correct at the time of signing, I will inform the company immediately if any of the information changes.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_