**COVID-19 Return to lab-work form**

The government has mandated that all employers issue this form for returning workers **at least 3 days** prior to their returning. Returning workers must complete and return the form to their employer.

The purpose of this exercise is to protect everyone by establishing that workers have no symptoms of COVID-19, that they are not self-isolating or awaiting the results of a COVID test.

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PI or line manager \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please answer Yes or No to the following questions and return the form to the Health and Safety Officer Darren Fayne** **fayned@tcd.ie**

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 in close contact with a person who is a confirmed or suspected case of COVID-19 in the past 14 days (i.e. less that 2 m 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**

**If you answer Yes to any question – do not come to work- stay at home and contact your GP.**

**Employees also must:**

• inform their employer if there are any other circumstances relating to COVID-19, not included in this form, that may need to be disclosed to allow their safe return to work.

• self-isolate at home and contact their GP promptly for further advice if they have any COVID-19 symptoms.

• stay out of work until all symptoms have cleared following self-isolation.

• participate in any induction training provided by the employer on their return to the workplace.

All employees must do a self-test every day before coming in to work. This includes checking for the presence of any symptoms of COVID-19.

**Daily Questionnaire**

Do you have any of the following symptoms:

1. A recent cough **Yes / No**
2. Shortness of breath **Yes / No**
3. Respiratory illness **Yes / No**
4. Fever **Yes / No**
5. Have you been advised to self-isolate in the past 14 days **Yes / No**

 **If you answer Yes to any question on this form do not come to work stay at home and call your GP.**