



Employee Self-Certification Form

Employee Name (please print) _____

Last 4 of Social Security Number _____

Date _____

Please note that Award Staffing is relying on your honesty to maintain the health and safety of the workplace.

1. RETURN FROM CONFIRMED COVID-19 ILLNESS OR COVID-19 SYMPTOMS

If employee has not been tested for COVID-19:

I, _____, certify that:

- I have not had a fever (100.4 F or higher) for at least 72 hours (that is without the use of fever-suppressing medicine); AND
- My symptoms, such as cough, fever, shortness of breath, chills, repeated shaking with chills, muscle pain, headache, sore throat, and or new loss of taste or smell, have improved; AND
- At least 7 days have passed since my symptoms first appeared.

If employee has been tested for COVID-19:

I, _____, certify that:

- I have not had a fever (100.4 F or higher) for at least 72 hours (that is without the use of fever-suppressing medicine); AND
- My symptoms, such as cough, fever, shortness of breath, chills, repeated shaking with chills, muscle pain, headache, sore throat, and or new loss of taste or smell, have improved; AND
- I have received a negative test, if possible, AND
- At least 7 days have passed since my symptoms first appeared.

2. RETURN FROM CARING FOR OR LIVING WITH AN INDIVIDUAL WHO HAS HAD CONFIRMED COVID-19 ILLNESS OR COVID-19 SYMPTOMS

I, _____, certify that:

- It has been 14 days since I have cared for or been in close contact* with an individual who has had confirmed covid-19 illness or covid-19 symptoms, AND

- I have not been ill with COVID-19 or experienced COVID-19-like symptoms, such as cough, fever, shortness of breath, chills, repeated shaking with chills, muscle pain, headache, sore throat, and or new loss of taste or smell, within the past 14 days.

*Close contact is defined by the CDC as (a) being within approximately 6 feet (2 meters) of a COVID-19 case for a prolonged period of time; close contact can occur while caring for, living with, visiting, or sharing a healthcare waiting area or room with a COVID-19 case, or (b) having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on).

3. RETURN FROM QUARANTINE OR TRAVEL TO LEVEL 3 AREA, INCLUDING NYC

I, _____, certify that I have not been ill with COVID-19 or experienced COVID-19-like symptoms, such as fever, cough, or shortness of breath, within the past 14 days. Furthermore, I certify that within the past 14 days, I have not visited any Level 3 Travel Health Notice Countries or NYC. For a list of such countries, please visit: <https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html>.

4. FACE COVERINGS

I, _____, acknowledge that the CDC recommends wearing cloth face coverings in public settings where other social distancing measures are difficult to maintain (*e.g., grocery stores and pharmacies*), especially in areas of significant community-based transmission.

CDC also advises the use of simple cloth face coverings to slow the spread of the virus and help people who may have the virus and do not know it from transmitting it to others. Cloth face coverings fashioned from household items or made at home from common materials at low cost can be used as an additional, voluntary public health measure.”

This policy is subject to change in accordance with any changes in circumstances or guidance from the CDC, public health officials, or government (federal, state, or local).

Employee Signature _____

NOTE - Completed form will be maintained in a confidential file, separate from your personnel file.