TOWN OF LAKE PLACID COVID19 CLEARANCE FOR RETURN TO WORK

EMPLOYEE NAME _____ EMPLOYEE DEPARTMENT _____

This form is prepared as and administrative review form for returning to work for the Town of Lake Placid in the event of any sickness related to COVID19 exposure. Department Heads must receive answers to the questions on this form by email or fax prior to the intended return and return to work must be authorized by the Town Administrator. This applies to all employees who are required to self-isolate because of a COVID 19 exposure or who are caretakers for a COVID19 patient. Employees are required to disclose all known exposures to COVID19. ATTACH ADDITIONAL PAGES TO THIS FORM IF NEEDED.

DESCRIPTION OF SYMPTOMS OR EXPOSURE TO COVID19 LEADING TO LEAVE BEING TAKEN (NOT APPLICABLE TO EXPOSURES WHO HAVE NOT BEEN SICK)

DID YOU SEE A PHYSICIAN AT THE START OF THE SICK LEAVE OR DID THE PERSON WHO WAS SUSPECTED OF HAVING COVID 19 SEE A PHYSICIAN?

PHYSICIAN'S NAME AND ADDRESS

DID PHYSICAIN AUTHORIZE COVID 19 TESTING FOR YOUR ILLNESS OR FOR THE PERSON YOU WERE EXPOSED TO YOUR KNOWLEDGE? _____

DID YOU RECEIVE TESTING?_____ DATE?_____ LOCATION? _____

TESTING ADMINISTERED BY WHAT ORGANIZATION _____

PROVIDE A COPY OF ALL TEST RESULTS AND DATE OF THE RESULTS BOTH POSITIVE OR NON-POSITIVE _____

PROVIDE COPY OF CLEARANCE FOR WORK AND CERTIFICATION OF NOT BEING CONTAGIOUS FROM PHYSICIAN _____

HAVE YOU HAD CONTACT WITH ANY TOWN OF LAKE PLACID EMPLOYEES SINCE BECOMING ILL OR BEING EXPOSED TO COVID19 (GIVE NAMES)?

HAVE YOU HAD CONTACT WITH ANY TOWN PROPERTIES OR TOWN VEHICLES WHILE BECOMING ILL OR BEING EXPOSED TO COVID19 (DESCRIBE IN ALL VEHICLES, WORKSPACES AND EQUIPMENT)

DO YOU CURRENTLY HAVE? HOW LONG HAS IT BEEN SINCE YOU HAD A FEVER? _____

- ☐ A fever (Describe how you determined this)
- ☐ Difficulty breathing
- ☐ A cough

IN YOUR OPINION ARE YOU CURRENTLY WELL ENOUGH TO RETURN TO WORK? _____

IN YOUR OPINION DOES RETURNING YOU TO WORK CONSTITUTE A THREAT TO OTHER TOWN EMPLOYEES? _____

DESCRIBE ANY ACCOMODATIONS, ONGOING MEDICAL TREATMENTS OR DRUGS YOU WILL NEED TO PERFORM THE FUNCTIONS OF YOUR JOB ONCE YOU RETURN TO WORK. _____

CAN YOU, AT THE TIME OF THIS REQUEST TO RETURN TO WORK, CONFIRM THAT YOU ARE COVID19 POSITIVE, HAVE EVER BEEN COVID 19 POSITIVE DURING THE PAST 14 DAYS OR HAVE BEEN EXPOSED TO A PERSON WHO IS COVID19 POSITIVE? _____

I attest that all of the information given to the Town of Lake Placid Staff regarding the above questions has been truthful and that I have disclosed all facts.

SIGNATURE _____ DATE _____ APPROVED FOR RETURN _____