COVID-19 Return to Work Certification Form
(For Employees Other than Healthcare Workers and Emergency Responders)

(*May be used if a Doctor's Note is not practicable*)

I, _____Name_____, certify that, at least fourteen (14) calendar days prior to the date of this certification, I either tested positive for COVID-19, exhibited symptoms of COVID-19, or had known exposure to an individual who tested positive for COVID-19.

I further certify the following:

- I have been free of fever (a "fever" is defined as 100.4° F [37.8° C] or greater using an oral thermometer) for at least 72 hours without the use of fever-reducing medicines;
- Any other signs of other COVID-19 related symptoms that I may have experienced, including my respiratory symptoms (*e.g.*, cough or shortness of breath) have significantly improved in the last 72 hours;
- At least 10 days have passed since the first appearance of any COVID-19 symptoms I may have; and
- I have complied with all directives provided to me by my health care provider before seeking to return to work, including, but not limited to, directives regarding the length of time that I need to self-isolate/quarantine, follow-up testing, and social distancing.

I understand that if I do present symptoms of COVID-19 (*e.g.*, fever, cough, or shortness of breath) after returning to work, I must inform my supervisor immediately and the County of Fresno _____Department_____ may either direct me to stay away from work or may require me to undergo a fitness for duty examination at the _____Department_____'s expense and according to the _____Department_____'s policy regarding fitness for duty examinations.

_____ _____

Signature Date