TULARE COUNTY OFFICE OF EDUCATION

RETURN TO WORK AFFIRMATION

This form is to be completed and signed by TCOE STAFF prior to returning to work at all TCOE sites for purposes of employment.

1. I have a fever or symptoms of a fever (Temperature over 100.4 degrees). Yes ☐ No ☐
2. I have a cough **not** due to a chronic or known condition. Yes ☐ No ☐
3. I am having difficulty breathing. Yes ☐ No ☐
4. I am experiencing chills, muscle pain, sore throat, or a new loss of taste or smell. Yes ☐ No ☐

   *****If you have indicated YES to questions 1-4, please stay home**, contact your health care provider, notify your direct TCOE supervisor and follow established leave procedures.

5. In order to comply with TCOE Health and Safety Protocols, I agree to conduct a Daily Self-Assessment to determine if I am well and symptom free prior to coming to work each day.
6. I will notify my direct TCOE supervisor if I experience any of the above symptoms of COVID 19, have been diagnosed with COVID 19, or have recently had close contact with a person diagnosed with COVID 19.

My signature below attest to the accuracy and compliance of the above information.

Name:______________________________

Signature:___________________________

Date:____________________

Time:____________________