Ventura County Community College District

Employee Certification to Return to Work After Exhibiting Symptoms of COVID-19 or Suspicion of Having or Being Exposed to COVID-19

Employees who have consulted with their healthcare provider after having had a COVID-19 diagnosis, symptoms, or exposure, and have been told by that provider that it is safe for them to return to work may do so upon providing appropriate certification from the health care provider. However, it is understood that the healthcare system is currently overwhelmed and may be unable to provide such certification. As a temporary measure, if an employee is unable to obtain timely certification from a health care provider, the employee may complete and submit this self-certification.

Employee Name:	Campus:	Employee ID:
Healthcare Provider Name:	Healthcare Provider Phone Number:	
Last day worked:	Date Healthcare Provider cleared the employee to return to work:	

I hereby certify the following (please initial each statement – all criteria must be initialed for either symptomatic or asymptomatic employees in order to return to work):

Symptomatic Employees (employees who experienced COVID-19 symptoms or diagnosis):

_____ I have used a thermometer to check my temperature and have not had a reading of 100.4 degrees Fahrenheit or higher in the past 72 hours. I have not used fever-reducing medication in the last 72 hours.

_____ I have not had any signs of any other COVID-19 related symptoms (e.g., cough, shortness of breath, diminished/loss of smell/taste, muscle aches) for at least 72 hours without the use of other symptom-altering medicines (e.g., cough suppressants).

_____ At least 7 days have passed since symptoms first appeared

_____ I have consulted with my healthcare provider and they have indicated that I may return to work.

Asymptomatic Employees (employees who had no symptoms- potential exposure):

_____ I have been exposed to but have not experienced any symptoms of COVID-19.

_____ I have consulted with my healthcare provider and they have indicated that I may return to work.

I authorize Human Resources to verify this information with the medical provider listed above. I understand that, if I do show further signs of having COVID-19 (e.g., fever, cough, shortness of breath, diminished/loss of smell/taste, muscle aches), I must inform my supervisor immediately and the District may either direct me to stay away from work or may require me to undergo a fitness for duty examination at the District's expense.

_____ _____ _____

Employee Signature **Phone Number** **Date**