# **Mississippi University for Women**

**COVID-19 Employee Self-Certification to Return to Work**

**Submit this form to Human Resources prior to returning to work.**

**W-1609 Fax: 662-241-7616 Email:** [**hrinfo@muw.edu**](mailto:hrinfo@muw.edu)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, attest to the following:

□ I have had no fever for at least three (3) days without taking medication to reduce fever during that time.

Date of last fever of 100.4 degrees or higher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ My respiratory symptoms (cough and shortness of breath) have improved.

Date respiratory symptoms began improving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (write N/A if no symptoms present)

□ At least fourteen (14) days have passed since my fever and/or respiratory symptoms began.

Date fever and/or respiratory symptoms began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ I was tested for COVID-19 and received a confirmed negative result.

□ I was quarantined but never experienced symptoms.

□ I was caring for an individual for COVID-19 related reasons and I am not experiencing symptoms.

Employee name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employee signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Today’s date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date returned to work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following is provided for an employee’s personal use to document his or her symptoms and recovery. This page should not be provided to the employer but kept for the employee’s personal records.**

Date symptoms began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of last fever of 100.4 degrees or higher: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date respiratory symptoms began improving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- |
| **Date** | **Temperature** | **Respiratory symptoms?**  **(Y/N)** | **Other symptoms or notes** |
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