MIAMI-DADE COUNTY
HUMAN RESOURCES DEPARTMENT

COVID-19 RETURN TO WORK AUTHORIZATION

Name (Last, First, Middle)	*Employee ID Number*	*Date of Birth*	*Phone Number (Cell)*	*Department Name*

I, _____, hereby certify that **ALL** of the following statements are true and accurate:

1. I tested positive for COVD-19 on ___/___/___.

2. I have had no fever for at least 24 hours without fever-reducing medication.
   a. Date of last fever of 100.4 F or higher: ___/___/___ OR
   b. Please initial here if you never had a fever: _____

3. At least 10 days have passed since my symptoms first appeared or since the date of my positive test if I did not experience symptoms.
   a. Date fever and/or symptoms first appeared: ___/___/___ OR
   b. Please initial here if you never experienced any symptoms: _____

4. My symptoms of COVID-19 are improving. (Note: Loss of taste and smell may persist for weeks or months after recovery and need not delay the end of isolation).

VOLUNTARY RETEST: Employees who choose to get retested and obtain a negative result, may return to work to after 7 days have passed since their symptoms first appeared or the date of their positive test, provided the negative test was taken on or after the 5th day of their quarantine period and the conditions listed in paragraphs 2 and 4 above have been met.

___ Please check here if you were voluntarily retested** following your positive test result and attach a copy of the test results to this form.

PLEASE NOTE THAT YOU ARE ONLY REQUIRED TO COMPLETE THE INFORMATION IN THE SECTION BELOW IF YOU ARE A PERSON WHO EXPERIENCED SEVERE TO CRITICAL SYMPTOMS OR ARE IMMUNOCOMPROMISED.

5. I experienced severe to critical* symptoms of COVID-19 or I am immunocompromised (e.g. being actively treated for cancer/chemotherapy for cancer, being within one year out from receiving a bone marrow or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200) and:

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a. At least 20 days have passed since the date of the positive test or since my symptoms first appeared.

- Date of positive test or when symptoms first appeared: ___/___/___

OR

b. I have attached a letter from my healthcare provider clearing me to return to work.

I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THE RETURN-TO-WORK CRITERIA AND HAVE COMPLIED WITH ALL REQUIREMENTS. I UNDERSTAND THAT MY DEPARTMENTAL PERSONNEL REPRESENTATIVE WILL REVIEW THIS INFORMATION AND MAY REQUIRE ADDITIONAL INFORMATION BEFORE RETURNING ME TO WORK.

_____ _____
Employee/Applicant (Signature in full) Date statement completed

DEPARTMENTAL PERSONNEL REPRESENTATIVE REVIEW/APPROVAL:

I HEREBY CERTIFY THAT I HAVE REVIEWED AND VERIFIED THE RETURN-TO-WORK CHECKLIST SIGNED BY:

EMPLOYEE NAME: _____

DPR OR DESIGNEE NAME: _____

_____ APPROVED or NOT APPROVED
Signature/Date (Circle one)

** The studies used to inform this guidance did not clearly define "severe" or "critical" illness. CDC has taken a conservative approach to define these categories (respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level ((or, for patients with chronic hypoxemia, a decrease from baseline of >3%)), or lung infiltrates >50%.)*

*** Please note that a negative test is not required to return to work, as long as the above conditions have all been met. If you have recovered from your symptoms after testing positive for COVID-19, you may continue to test positive for three months or more without being contagious to others. For this reason, you should be tested only if you develop new symptoms of possible COVID-19. Getting tested again should be discussed with your healthcare provider, especially if you have been in close contact with another person who has tested positive for COVID-19 in the last 14 days.*

Revised 2/22/2021