Mississippi Band of Choctaw Indians
COVID-19 Employee Self-Certification to Return to Work Form

I, ______________________, certify that, at least ten (10) 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 had no fever for at least three (3) days without taking medication to reduce fever during that time.
  
  Date of last fever: ___________________

- My respiratory symptoms (cough and shortness of breath) have improved for at least three (3) days.
  
  Date respiratory symptoms began improving: ________________
  
  (write N/A if no symptoms present)

- At least seven days have passed since my fever and/or respiratory symptoms began.
  
  Date fever and/or respiratory symptoms began: ________________

- I have complied with all directives to me by my health care provider before seeking to return to work, including, but not limited to, directive 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 (listed above) after returning to work, I must inform my supervisor immediately. Failure to notify my supervisor and/or knowingly expose others may result in further disciplinary action including termination.

Employee Name: _____________________________________
Employee Signature: ___________________________________
Today’s Date: __________________________________________________________________
Date return to work: __________________________________________________________________

Supervisor Signature: ___________________________________
Date Received: ___________________________________________________________________