



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: _____