DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health

RETURN TO WORK/ MEDICAL VERIFICATION FORM

EMPLOYEE TO COMPLETE

Employee Name: _____ DOB: _____

Phone number:_____ Email: _____

Job Title: _____ Department:_____

PHYSICIAN/PROVIDER CERTIFICATION

Today's Date: _____Date of initial assessment: _____

Presenting symptoms: ◯ Fever ◯ Cough ◯ Shortness of Breath ◯ Other (please describe):

_____

- Was the patient tested for influenza? (Please circle one) **Yes** **No**
  - What were the results? **Positive Flu A** **Positive Flu B** **Negative**

- Was the patient **screened** for COVID-19? **Yes** **No**
- Was the patient **tested** for COVID-19? **Yes** **No**
  - Results: **Positive** **Negative**
- Was the patient advised to be quarantined? **Yes** **No**
  - For how long?_____
  - Start Date:_____ End Date:_____

*****By signing below, you attest to having seen and assessed the above patient, and from today's assessment, you believe the above patient may return to work without any current risk of infecting others with any form of communicable disease.**

_____

Signature **Date** **Time**

_____

Printed name **Phone number**

_____

Office Address **City** **State** **Zip Code**

Revised 3/14/2020