Pre- Return Form

(For completion over the phone with employees, at least THREE DAYS before returning to the premises during the "Emergency Period".

EMPLOYEE NAME: DEPARTMENT:

1st DAY OF LEAVE OF ABSENCE:

EXPECTED DATE OF RETURN TO WORK:

COVID 19

1. In the last 14 days, have you been diagnosed with COVID-19 or suffered from any of the following symptoms (fever, shortness of breath, breathing difficulties or a cough)? **YES/NO**

If YES, please answer the following questions.

Please provide specific details of your diagnosis and symptoms below:

Details of diagnosis or symptoms:

Have you contacted your GP/HSE regarding your symptoms? **YES / NO**

If **NO**, we need you to speak with the HSE/GP to validate that you can return to work.

If **YES**, please details their suggested course of action below?

HSE/GP recommendations:

2. In the last 14 days have you returned from overseas travel? **YES/NO**

If YES, please answer the following questions.

Have you been required to self-isolate, please provide details below:

Details of Self-Isolation: (Start and finish date)

3. In the last 14 days have you been in contact with a case of COVID-19? **YES/NO**

If YES, please answer the following questions.

Have you contacted your GP/HSE regarding this? **YES / NO**

If **NO**, we need you to speak with the HSE/GP to validate that you can return to work.

If **YES**, please detail their suggested course of action below?

HSE/GP recommendations:

4. In the last 14 days have you attended a healthcare facility where patients with COVID-19 were being treated? **YES/NO**

If YES, please answer the following questions.

Have you contacted your GP/HSE regarding this? **YES / NO**

If **NO**, we need you to speak with the HSE/GP to validate that you can return to work.

If **YES**, please details their suggested course of action below?

HSE/GP recommendations:

5. Are you awaiting test or the results of the test for COVID-19? **YES/NO**

If YES, please give details below.

An individual diagnosed with or suffering from COVID-19 symptoms within the last 14 days, must provide written confirmation from their GP/HSE fitness to return to work before they can return. See 'Fitness to return to work 'section below.

FITNESS TO RETURN TO WORK / Long Term Illness / Injury

(To be completed when necessary)

Has the doctor/HSE confirmed your fitness to return to your previous duties and responsibilities, work area and working hours: **YES / NO /N. A (Not applicable)**

Have you provided the certification of this? **YES / NO/ N. A**

Do you feel capable to return to your previous duties and responsibilities, work area or working hours: **YES / NO /N. A**

If **NO**, details:

Have you fully read the updated social distancing guidelines and up to date risk assessments for your work area, understood them and agree to adhere to them on your return?

YES / NO /NEED FURTHER GUIDANCE

Please record any additional information you believe that the Company should be aware of before your return to work:

INTERVIEW COMPLETED BY:

EMPLOYEE SIGNATURE:

DATE: