**Irish Tai Chi Chuan Association**

# COVID-19 PRE-RETURN FORM - Therapist / Instructor

| | |
|---|---|
| Name | |
| Returning to work date | |

| | Signed |
|---|---|
| To be best of your knowledge can you confirm you have no symptoms of COVID-19 | |
| Please confirm that you are not self-isolating and are not awaiting COVID-19 test results | |

| | Yes | No |
|---|---|---|
| Do you have symptoms of cough, fever, high temperature, sore throat, runny nose, breathlessness or flu like symptoms now or in the last 14 days- Please indicate yes/no opposite | | |
| Have you been diagnosed with confirmed or suspected COVID-19 infection in the last 14 days. | | |
| Are you a close contact of a person who is confirmed or suspected case of COVID-19 in the past 14 days? (i.e. less than 2m for more than 15 minutes accumulative in one day) | | |
| Have you been advised by a doctor to self-isolate at this time? | | |
| Have you been advised by a doctor to cocoon at this time? | | |

If there are any changes in symptoms, suspected or confirmed COVID-19 infection, close contact with a suspected/confirmed case, doctors advice on isolation etc after you return to work then please inform your supervisor re same.

Signed _____ Date _____