Town of Fairhaven
Massachusetts
Office of the Town Administrator
40 Center Street
Fairhaven, MA 02719
508-979-4023

Date: April 21, 2020

To: All Departments

From: Mark Rees, Town Administrator

Cc: Board of Selectmen
Health Office
Human Resources

Re: Return to Work Form after COVID symptoms, exposure

Attached to this memo, please find a form that employees will be asked to complete in the event they experience COVID symptoms, have traveled to a high-risk region, or have potentially been exposed to a COVID patient. Please note that this form should be distributed to all employees, but is only necessary to complete in the event of symptoms or potential exposure. Going forward, this additional precaution will assist us in returning on-site staffing levels to normal while protecting the workplace and the community. In addition to completing the attached form, employees will be held to the following return-to-work precautions:

Decisions as to when an employee may return to work and under what conditions an employee may return will be made on a case-by-case basis, consistent with federal and state guidelines, to protect the safety of all employees and the public. Similarly, what kind of leave – such as sick leave, FFCRA leave, administrative leave, etc. – will be determined as the circumstance warrants, consistent with existing collective bargaining agreements, rules, and regulations.

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Tel: (508) 979-4023
Fax: (508) 979-4079

COVID-19 Health Questionnaire

Instructions: Complete this form at least twenty-four (24) hours prior to reporting to work, if you are symptomatic, have traveled, or have possibly been exposed to COVID-19. Please complete this form and submit to your supervisor with a copy to Human Resources at: HR@Fairhaven-MA.gov or 508-979-4079. If you do not have access to a computer, please call your supervisor. **If you answer 'yes' to any of the questions below, do not report to work until you have been permitted to return by your supervisor.**

Name: ___________________________ Date: _________________________

Email address: _______________________________________

Telephone: _______________________________________

Department: _____________________ Supervisor: ___________________

To be completed by employee:

Do you have any of the following symptoms?

1.	Fever of 100.4 degrees (F) or greater	Yes		No	
2.	Cough	Yes		No	
3.	Difficulty breathing/shortness of breath	Yes		No	
4.	Chills	Yes		No	
5.	Unexplained tiredness and/or confusion	Yes		No	
6.	Body aches	Yes		No	
7.	Unexplained loss of smell or taste	Yes		No	

Other:

1.	Have you had close personal contact with anyone in the past 14 days who is now exhibiting any of the above symptoms?	Yes		No	
2.	Have you been in close contact with anyone who has tested positive for COVID-19?	Yes		No	
3.	Do you have any reason to believe that you may have been exposed to COVID-19?	Yes		No	
4.	Have you traveled outside of the United States in the past 21 days?	Yes		No	
	a. If yes to #4, to which country did you travel?				
	b. If yes to #4, what dates did you travel?				

Comments or additional information:

Employee signature: ____

Supervisor signature: ____