



Referral to Medical Services Notice Template (Contractor)

Date: _____

It has been determined that you are exhibiting symptoms of COVID-19 or have had close contact with someone designated as COVID-19 positive, and as a result you are unable to remain at work.

Exhibiting Symptoms

If you are exhibiting symptoms of COVID-19: You are required to have your healthcare provider complete the attached "**Return to Work Status Form**" for the purpose of determining your ability to perform your return to work and be free from any contagious diseases.

We ask that your healthcare provider review the "**Return to Work Status Form**" and complete it to determine your eligibility to return to this location.

Please have the form completed and returned your organization who will contact the agency/worksite/office to determine a return to work date.

You are instructed not to return to work until you or your healthcare provider have submitted your "**Return to Work Status Report**" and you have spoken with your organization about a return to work date.

Close Contact

If you were identified as a close contact of someone designated as COVID-19 positive you must quarantine for 14 calendar days. In addition you are required to have your healthcare provider complete the attached "**Return to Work Status Form**".