**Insert Practice Information**

**TEMPLATE #1A-POSSIBLY CONTAGIOUS**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To whom it may concern,

This certifies that the patient has been under our care for the symptoms potentially associated with COVID-19 and has been directed to stay home for 14 days since onset of the symptoms which may be contagious.

Thank you for your understanding.

Sincerely,

Physician/Provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insert Practice Information**

**TEMPLATE #1B-POSSIBLY CONTAGIOUS**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To whom it may concern,

This certifies that the patient has been under our care for the symptoms below and has been directed to stay home for 14 days since onset of the following symptoms which may be contagious. Symptoms of concern are:

( ) Fever
( ) Cough
( ) Shortness of Breath
( ) Body Aches
( ) Fatigue

( ) Vomiting

( ) Diarrhea

Thank you for your understanding.

Sincerely,

Physician/Provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insert Practice Information**

**TEMPLATE #2 - SYMPTOMS WITHOUT TESTING**

Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ attests that

* The patient had a fever and a cough without COVID-19 testing or medical care, and that
* Three days have passed since their recovery, fever has resolved without the use of fever-reducing medication and their respiratory symptoms have improved; and that
* At least seven days have passed since the patient first experienced symptoms; and the patient
 notified physician/provider

Sincerely,

Physician/Provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Physician/Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insert Practice Information**

**TEMPLATE #3- CONFIRMED AND SHOWING SYMPTOMS**

Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was medically confirmed to have COVID-19 and can now return to work since

* Their fever has been resolved without the use of fever-reducing medications;
* Their respiratory symptoms have resolved and
* They have had two negative COVID-19 tests.

I certify that, with regard to COVID-19 the above-named patient is fit for duty and able to resume work effective\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Sincerely,

Physician/Provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insert Practice Information**

**TEMPLATE #4- CONFIRMED WITH NO SYMPTOMS**

Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was medically confirmed to have COVID-19 and can now return to work since

* 7 days have passed since the date of their first positive COVID-19 laboratory test and;
* The patient is not showing signs of illness and
* The patient has had no subsequent illness

I certify that, with regard to COVID-19 the employee is fit for duty and able to resume work effective\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Sincerely,

Physician/Provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Provider signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_