***Form to be completed by Site Medical Director or Executive Director and emailed to*** ***occupationalhealthnursing@phsa.ca***

 **Employee ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_ Employee name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Worksite: \_\_\_\_\_\_\_\_\_\_\_\_\_ Job title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of return from travel: \_\_\_\_\_\_\_\_\_\_\_\_\_ Country travelled to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Duration of travel (days): \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please confirm the following:**

**[ ] Employee and members of their household are not exhibiting symptoms of COVID-19**

**[ ] Employee will self-monitor for symptoms for 14-days and follow Infection Control/Health and Safety PPE requirements**

**[ ] Employee’s manager has attempted backfill and/or reorganization of work to enable self-isolation**

|  |
| --- |
| **Describe how services will not be deliverable if the employee must self-isolate from work and the impact to patient care or service delivery:**  |
|  |
| **Asses the risk of an employee returning to work before self-isolation, including: area visited, activities undertaken during travel (e.g. large gatherings), work environment, and overall risk and impact of transmission upon return.** |
|  |

**This exemption has been:**

**[ ] Approved [ ] Declined**

 **Site Medical Director or Executive Director signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Site Medical Director or Executive Director name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Revised: October 15, 2020