Name:_____ CWID:_____

COVID-19 RETURN TO CAMPUS CERTIFICATION

Complete options 1, 2, or 3 depending on your circumstances.

1. POSITIVE OR SYMPTOMATIC: For individuals who tested positive for COVID-19 with symptoms or had symptoms of COVID-19 and were in isolation:

I hereby certify the following:

☐ At least 24 hours have passed since my last fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**, at least 10 days have passed since symptoms first appeared.

OR

☐ Resolution of fever without the use of fever-reducing medications **and** Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and** negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from a respiratory specimen.

2. ASYMPTOMATIC: For individuals who tested positive for COVID-19 who have NOT had symptoms:

I hereby certify the following:

☐ At least 10 days have passed since the date of my first positive COVID-19 diagnostic test and I have not subsequently developed symptoms.

3. DIRECT CONTACT: For individuals who were exposed to COVID-19 and have been in quarantine:

I hereby certify the following:

☐ At least 14 days have passed from the last date of my known exposure to COVID-19 **and** I have not developed symptoms.

The certification made above is true and correct to the best of my knowledge and belief. I acknowledge and understand that being accurate and correct is not only important for my health and safety, but for the health and safety of others on campus.

_____ _____ _____

Signature Today's Date Expected return Date