County of San Bernardino
Center for Employee Health
and Wellness
COVID – 19 RTW form

*** Please submit this completed form directly to CEHW at HR-MedicalRecords@hr.sbcounty.gov**
Please send positive results or MD note with this form.

Name: _____ **Phone :** _____

EE ID # _____ **Date of Birth:** _____

Department: _____ **Job Title:** _____
To schedule appointment if needed:

Supervisor Name: _____ **Phone:** _____

What was the date your symptoms first began? _____

Description of Symptoms: _____

_____

Did you have a COVID test? Yes ☐ **No** ☐

Date COVID test performed_____ **COVID Test Results** _____

What was last date you had a fever? _____

Never had a fever ☐

When did your symptoms improve/resolve? _____

Symptoms have not resolved ☐

List remaining symptoms if present: _____

Is there any medical reason you cannot return to work? Yes ☐ **No** ☐ **If yes, please describe:**

Consent for Medical Evaluation:

The undersigned consents to having a return to work evaluation.

Signature: _____ **Date/Time:** _____
(Client/Representative - indicate relationship)

Signature: _____ **Date/Time:** _____
(Witness)