FORT BRAGG NORTH CAROLINA
DEPARTMENT OF PUBLIC HEALTH
PREVENT. PROMOTE. PROTECT.

Return to Work Certificate

Name: _____ Today's Date: _____

Job Position/Grade/Series/Rank: _____

Supervisor/Command: _____ Email: _____

Supervisor/Command telephone number: _____

Employee was evaluated on _____ *(date)* and quarantined due to medical condition.

Reason for evaluation:

☑ Medical condition requires **quarantine for 14 days**

☑ Other (*Explain below*)

The date you were actually screened

You were placed on quarantine due to exposure to COVID-19 on _____. Upon completion of **14-days quarantine**, you have met public health guidelines for release from quarantine and are able to return to regular activities (14-days without developing symptoms of COVID-19). Please contact your provider for clinical follow up if needed. **Note:** for household close contacts, your quarantine period will start on the last day of your household's isolation period.

The date you can return to work

Recommendation:

☑ Able to return to work without restriction on _____ **(14 days from date of last exposure).**

☑ Unable to return to work until 14 days since exposure or instruction. Restrictions are valid until N/A – Please visit the Womack website at https://womack.tricare.mil for additional information or call 910-907-2778 (907-APPT) to schedule a follow up appointment with your WAMC Primary Care Provider.

Physician or other licensed practitioner stamp or signature – * required fields

*Signature: _____

*Print Name: _____

*Occupation: _____

*Clinic: _____

*Phone/Email: _____

Visit https://womack.tricare.mil for questions

Completed by the Emergency Department

Stamp