**CORONAVIRUS - STAFF HEALTH RISK ASSESSMENT FORM / RETURN TO WORK**

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| --- | --- |
| **Employee’s Name** |  |
| **Date of Birth** |  |
| **Home Address** |  |
| **Home Tel no.** |  |
| **Mobile Tel no.** |  |
| **Job Title/Role** |  |
| **Name of Care Service** |  |

**Covid 19 – Testing History**

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| --- | --- | --- |
| **Date of Covid 19 test**  | **Result** | **Action**  |
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**WORK ADJUSTMENT/RETURN TO WORK ASSESSMENT (COVID 19)**

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| --- | --- | --- |
| **Employee Name:** | **Manager Name:** | **Date:** |
| **Job Title:**  | **Home:**  |  |
| **Relevant factors / health condition(s):** | 1. *70+ years old*
2. *Eg: Asthma*
 |
| **Impact of health condition(s) on ability to undertake job:** | 1. *Eg: to avoid care of Covid + residents*
2.
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| --- | --- | --- | --- |
| **Risk Management Measures implemented**  | **Has risk management adjustment been implemented Yes / No****If not, why not?** | **Review Date** | **Following Risk Management Measures, is it safe for the individual to return to work?**  |
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| --- | --- |
| **Is there any adjustment/any other support I have not discussed with you that you consider would support you in your role?** |  |
| **Detail any other alternatives considered by service to support employee** |  |

Manager’s signature/ job title……………………….………………………..………………… Date: …………………….

Employee’s signature/ job title…………………………………………………………….…….Date: …………………….