**COVID-19 Employee Return to Work Checklist**

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| **Employee Name:** |  | **Work Location/ Department:**  |  |
| **Checklist Completed by:** |  | **Date:** |  |

***\*Please complete the action plan at the end of the checklist for any further improvements needed***

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| --- | --- | --- | --- |
| **Employee Return to Work Planning** | **Yes** | **No** | **N/A** |
| Can the employee continue to/ work from home with regular contact and a review of circumstances? |  |  |  |
| Has the employee been identified as high risk/ vulnerable/ shielded? |   |   |   |
| Has the employee expressed concern about any other condition which they feel would make them more vulnerable e.g. mild asthma? |  |  |  |
| Is the employee required to carry out work in breach of 2 metre social distancing from both work colleagues and non-employees? |   |   |   |
| Does the employees work involve touching surfaces that are or could be potentially contaminated? |  |  |  |
| Is there a higher risk of infection due to the work environment e.g. regular visits to different locations or densely populated workplaces? |  |  |  |
| Have you consulted with the employee and developed job role-specific instructions in relation to COVID-19, prior to them attending the workplace? Have you requested declarations of agreement which are signed and dated? |   |   |   |
| Has the employee expressed any concern regarding returning to the workplace and do you have arrangements in place to provide support for anxiety or stress related conditions? |   |   |   |
| Have you provided training and briefings for the employee’s Managers to support staff in the transition period? |   |   |   |
| Have you established a review process where each employees’ job role will be reviewed on a regular basis? |  |  |  |

**\*Action Plan**

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| **If ‘No’ - Further Action Identified** | **Responsible Person** | **Timescale** | **Date Completed and Closed Off** |
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