Workplace COVID-19 Risk Consent Form

Please read and acknowledge the following information regarding the health risks associated with COVID-19 in the workplace.

Personal Details

Full Name

Position / Job Title

Date

COVID-19 Risk Acknowledgment

☐ I acknowledge that I have read and understood the health risks associated with COVID-19 in the workplace.

☐ I confirm that I am not currently experiencing symptoms related to COVID-19 and have not knowingly been in contact with a confirmed case in the past 14 days.

☐ I agree to adhere to all workplace safety protocols established to reduce the spread of COVID-19.

Consent & Signature

Signature

Employee Signature

Date