Muscular Dystrophy Society of Ireland (Company Limited by Guarantee)
75 Lucan Road
Chapelizod
Dublin 20 - D20 DR77
Tel: (01) 6236414/5

Dear

You will find enclosed our Covid 19 Response Plan on managing coronavirus in the workplace.

In creating this Response Plan, we do not wish to cause any undue alarm or concern. However, the current situation is developing, and we must, as a company, prepare to take steps to deal with any issues that may arise, because of the virus, which could affect you. Your health, safety and wellbeing are an extremely high priority of ours and so we have devised this Response Plan to help us ensure our normal high standards in this regard.

We all have a duty at this time to ensure the spread of the virus is as minimal as possible, and we ask that you read this Response Plan and follow the guidance within.

As part of our Response Plan, all employees must complete a Pre Return to Work Form three days before commencing back to the workplace. This questionnaire must be fully completed and returned to your Line Manager.

If you have any questions, please do not hesitate to contact your line Manager.

Yours sincerely,

Elaine McDonnell
CEO
Muscular Dystrophy Ireland

Covid-19 Pre Return to Work Questionnaire for Employees

Please use your own pen when completing this questionnaire. Employees must complete this questionnaire at least 3 days prior to returning to work.

If you indicate to us you have symptoms of COVID-19, or if you have been abroad in the last 14 days (with the exception to Northern Ireland), in accordance with Government guidance, you will be required to seek a professional medical assessment before being permitted to return to work.

Employee Details	
Name:	
Work area:	
Mobile No:	
Email:	
Date:	

Questionnaire	Yes	No
Do you currently have, or have you ever been diagnosed as having, Covid-19?		
Have you travelled abroad in the last 14 days?		
If yes please state where:		
Have you displayed any symptoms of Covid-19 in the last 14 days, namely fever, high temperature, persistent coughing, breathing difficulties / shortness of breath, and, or loss of taste or smell?		
If yes, which symptom(s) have you displayed		
Do you live in the same household as someone, or have been in close contact with someone, who has displayed symptoms of Covid-19 in the last 14 days or who has a confirmed case of Covid-19?		
If yes, please provide details:		
If you answered Yes to any of the foregoing questions, have you consulted a Doctor or other medical practitioner?		
Have you been advised by a doctor to cocoon at this time?		
Have you been advised by a doctor to self-isolate at this time?		

Do you travel alone to your place of work?		
Do you object to your temperature being taken before entering the premises?		

NOTE: When in the workplace, please ensure you follow Company policy in respect of Covid-19, to include our workplace standard procedures regarding infection control (e.g. hand washing/hand sanitising, general coughing/sneezing etiquette, etc.). Information supplied in this questionnaire by our employees may be shared with direct work related contacts where you are attending their premises for the provision of our services, or where they come into contact with you whilst you are performing your work duties.

I confirm that the above information is accurate to the best of my knowledge:

Print name: _____

Signature: _____ **Date**: _____

EMPLOYEE CONTACT TRACING LOG BOOK

Please Complete Using Your Own Pen

This information will only be used in the event of an emergency or if contact tracing is required for Covid-19.

Employee Details	
Name:	
Mobile No:	
Email:	
Date:	

Please provide details of clients / persons you came into contact with today as part of your working duties.

Name of Contact	Company	Reason for Meeting