**Return to Work (from Shielding) Interview Form**

***To be completed by the line manager during the Return to Work Meeting and signed by the employee and the line manager.*** ***If a fit note for restricted duties has been submitted or the manager feels that restrictions to duties should be put in place, please also complete Page 2.***

***An Individual Risk Assessment must also be completed.***

***Send completed forms to gb-hrcentraladmin***

***Please discuss anyone returning from shielding who may be considered vulnerable or extremely vulnerable with your HRBP***

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| --- | --- | --- | --- |
| **Employee Name** |  | **Job Title** |  |
| **Employee Number** |  | **Location** |  |
|  |
| **First day of absence** |  | **Last day of absence** |  |
|  |
| **Did employee consult their doctor?** | **YES/NO** |
| **Any specific advice given by the doctor associated with a return to work from shielding?** |
| **Doctor’s Name and Address:** |
|  |
| **Reason employee was shielding (is there an underlying medical condition):** |
| **How does the employee feel about returning to work (any concerns/retraining required, please note discussion)?** |
| **Employee’s current state of health?** |
| **Any indications that the employee should not return to normal duties, or are adjustments required?** |
| **Discuss implemented changes to workstation/site. Check understanding. YES/NO**  |
| **Explain COVID Protocols. Check understanding. YES/NO** |
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| **Does the employee feel fit and safe to return to work?** |
| **Will the employee have to use public transport to get in to work? (If yes, consider working hours to accommodate travel at non-peak times)** |
|  |  |
| **Employee Signature** | **Date** |
| **Line Manager Signature** | **Date** |

**Return to Work (from Shielding) Interview Form continued**

|  |  |  |  |
| --- | --- | --- | --- |
| **Employee Name** |  | **Job Title** |  |
| **Employee Number** |  | **Location** |  |
|  |
| **First day of absence** |  | **Last day of absence** |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Have you agreed any measures or temporary adjustments which are specific to the employee? (please tick)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Altered Hours** |  | **Phased Return to Work** |  |
|  |  |  |  |
| **Amended Duties** |  | **Workplace Adaptions** |  |

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| **Please give a brief description of current job role:**  |
| **Please state modifications required to facilitate a return to work:** |
| **Are any modifications or adjustments required which cannot be accommodated?****YES/NO** ***If, yes, please consult your HR BP*** |

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| **Actions** |
| Date that a further review is required \_\_\_/\_\_\_/\_\_\_\_\_Do you require the employee to be assessed by an Occupational Physician? YES/ NO***if yes contact HR BP to discuss referral***  |

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| --- |
| *I understand and agree with the temporary measures set out above and that they are subject to review. I will notify my manager if I have any concerns or difficulties in carrying out these duties.* |
| **Employee Signature** | **Date** |

|  |  |
| --- | --- |
| **Line Manager Signature** | **Date** |