Employee Travel Disclosure

Please provide your supervisor with a completed and signed copy

Employee Name: _____Position Title: _____Date:_____

Employee ID #:_____

Anticipated Travel Start Date:_____

Anticipated Travel Return Date:_____

I will be traveling to the following foreign locations: (please print clearly name of country and region or town)

_____

_____

_____

_____

_____

I understand that in the interest of my safety, the safety of my patients and the health and safety of the public that if I travel to a foreign location at risk for the Covid-19 I may not be able to return to work for a period of time as per the The New Jersey State guidelines at the time of my return. I understand it is my responsibility to notify my supervisor immediately if I develop symptoms and cannot return to work following this travel.

If I am unable to return to work following my travel, I understand I will be paid in accordance with standard PTO and/or leave of absence policies where applicable.

If I begin to experience any symptoms I will notify my physician. If I become ill I understand I can apply for a leave of absence and may be eligible for short term disability. I will contact Absolve at 800-401-2691 to initiate the leave claim process.

Print Name: _____Signature:_____Date: _____