



**FlexRN Quarantine Authorization**

A Medical Facility supervisor/official must provide written confirmation that the FlexRN Nurse is **required** to be quarantined during an assignment at the Medical Facility effective \_\_\_\_\_.

FlexRN Nurse: \_\_\_\_\_

A Medical Facility supervisor/official must check an option below:

\_\_\_ The FlexRN Nurse is NOT required to self-quarantine but is to self-monitor temp twice daily and any symptoms for \_\_\_\_\_ days and report any fever or symptoms immediately.

\_\_\_ The FlexRN Nurse is required to self-quarantine for 14 days.

\_\_\_ The FlexRN Nurse is required to self-quarantine for \_\_\_\_ days.

\_\_\_ The FlexRN Nurse is required to quarantine at an authorized quarantine site for \_\_\_\_ days.

Reason for quarantine:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Facility Supervisor/Official

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Name, Title

\_\_\_\_\_  
Facility