Interim Return to Work Guidance for Healthcare Personnel with COVID-19, Influenza, RSV, and Other Acute Viral Respiratory Infections

The recommendations in this document are not regulatory in nature, except when required by a regulatory agency such as Washington State Department of Labor & Industries (L&I), Washington State Department of Social and Health Services (DSHS), DOH-Health Systems Quality Assurance (HSQA), and Centers for Medicaid and Medicare Services (CMS). When creating policy and procedures, healthcare settings should ensure they meet regulatory requirements.

Background

The Washington State Department of Health (DOH) has updated guidance based on draft guidelines developed by the Healthcare Infection Control Practices Advisory Committee (HICPAC) Healthcare Personnel Guideline Workgroup (HCP-WG). HICPAC was in the process of updating the 1998 "Infection Control in Healthcare Personnel" guideline prior to the dissolution of HICPAC in June 2025. The purpose of this guidance is to reduce the risk of transmission of viral respiratory infections to patients, visitors, and other HCP while balancing the risk to patient safety and workforce fitness for duty with prolonged work exclusions and workforce strain.

These interim recommendations provide guidelines on the return-to-work (RTW) of healthcare personnel (HCP) with suspected or confirmed viral respiratory infections, including SARS-CoV-2 (COVID-19), seasonal influenza (flu), Respiratory Syncytial Virus (RSV), and other acute respiratory infections that are not otherwise specified in public health guidance. See glossary on the last page for the definition of acute viral respiratory infection used in this guidance.

This guidance does not apply to viral infections for which specific public health guidance is available, including novel viral pathogens. Follow any additional Local Health Jurisdiction recommendations. Additional measures may be recommended by public health during situations such as periods of high community circulation and in response to outbreaks.

This guidance applies to all paid and unpaid individuals serving in healthcare settings and also applies to healthcare personnel providing healthcare services in other settings.

Work restrictions for HCP with suspected or confirmed viral respiratory infection, including COVID-19, flu, and RSV

HCP with a suspected or confirmed viral respiratory infection should:

- Be restricted from work until:
    - At least 3 days* have passed since symptom onset (or since their positive test result if asymptomatic) **AND**
    - **BOTH** of the following have been true for at least 24 hours:
        - Fever-free without the use of fever-reducing medication
        - Symptoms are improving and HCP feels well enough to work
- Wear source control upon return to work until the end of 10 days*
- Strict adherence to hand hygiene, respiratory hygiene, and cough etiquette.

**Day 0 is the first day of symptoms or the first positive test, if asymptomatic throughout their infection.*

High-Risk Populations

Patients at Highest Risk of Severe Illness

- Consider additional measures, such as prolonged work restriction or temporary reassignment, for HCP who care for or work on a unit with patients at the highest risk for a severe illness due to viral infections, such as moderate to severely immunocompromised patients. Examples of these locations may include hematology/oncology, reverse isolation settings, and transplant units. The healthcare facility administrator should determine where these additional measures apply.
- Exclude HCP who have a suspected or confirmed viral respiratory infection from working in units or clinics serving patients who are at highest risk for severe illness due to viral infections until:
    - At least 10 days* have passed since symptom onset or first positive test result **AND**
    - **BOTH** of the following have been true for at least 24 hours:
        - Fever-free without the use of fever-reducing medication
        - Symptoms are improving and HCP feels well enough to work

HCP with High Risk of Severe Illness

- HCP who are moderate to severely immunocompromised and are suspected or confirmed to have a viral respiratory infection may shed virus for longer periods. Consider consulting with occupational health, an infectious disease expert, and/or using a test-based strategy to determine if an extended period of work exclusion or source control use may be indicated.
- Tailor preventive actions to each situation and individual, using the degree of immunocompromise as determined by the HCP's provider.

Voluntary PPE Use

- Ensure PPE is accessible to staff. Staff may want to wear PPE, such as procedure masks and N95 respirators, to protect themselves or someone in their household from exposures to viral respiratory infections, beyond when it is recommended within this guidance.
- HCP may voluntarily use PPE above the minimum guidelines and policies, as long as it does not introduce hazards or conflict with workplace requirements. For additional details, refer to WAC 296-800-16080

Glossary of Key Terms

Healthcare Personnel (HCP): HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

Source Control: Well-fitting masks or respirators to cover the wearer's mouth and nose to prevent spread of their respiratory secretions to others when they are breathing, talking, sneezing, or coughing.

- Respirators and masks provide varying levels of protection to the wearer and those around them. Common source control device options include, but are not limited to:
    - NIOSH-approved N95 filtering facepiece respirator without an exhalation valve
    - Well-fitting surgical or procedure mask
- It is Best Practice to use a fit-tested NIOSH-approved N95 filtering facepiece respirator without an exhalation valve, since evidence indicates that it is more effective than procedure and surgical masks at filtering infectious particles from exhaled air.
- More information about the level of performance of different types of source control is available from NIOSH Respirators and Mask Types and Performance.
- If respirator use is required for HCP, Safety Standards for Respirators should be followed (WAC 296-842).
- Cloth masks are not typically acceptable for use as source control in healthcare settings.

Viral Respiratory Infection: For this guidance, suspected viral respiratory infection is defined as the presence of 2 or more signs or symptoms such as cough, fever, chills, headache, sore or scratchy throat, runny or stuffy nose, sneezing, chest discomfort, decrease in appetite, vomiting, diarrhea, fatigue, muscle or body aches, new loss of taste or smell, weakness, and wheezing that is not otherwise attributed to another diagnosis or chronic condition.

Moderate to severe immunocompromising conditions and treatments include, but are not limited to:

Active treatment for solid tumors and hematologic malignancies
Hematologic malignancies associated with poor responses to COVID-19 vaccines regardless of current treatment status (e.g., chronic lymphocytic leukemia, non-Hodgkin lymphoma, multiple myeloma, acute leukemia)
Receipt of a solid-organ transplant or an islet transplant and taking immunosuppressive therapy
Receipt of chimeric antigen receptor (CAR)-T-cell therapy or hematopoietic cell transplant (HCT) (within 2 years of transplantation or taking immunosuppressive therapy)
Moderate or severe primary immunodeficiency (e.g., common variable immunodeficiency disease, severe combined immunodeficiency, DiGeorge syndrome, Wiskott-Aldrich syndrome) Advanced HIV infection (people with HIV and CD4 cell counts less than 200/mm^3, history of an AIDS-defining illness without immune reconstitution, or clinical manifestations of symptomatic HIV) or untreated HIV infection
Active treatment with high-dose corticosteroids (i.e., 20 mg or more of prednisone or equivalent per day when administered for 2 or more weeks), alkylating agents, antimetabolites, transplant-related immunosuppressive drugs, cancer chemotherapeutic agents classified as severely immunosuppressive, tumor necrosis factor (TNF) blockers, and other biologic agents that are immunosuppressive or immunomodulatory (e.g., B-cell-depleting agents)

Resources

DOH | COVID-19 Infection Prevention in Healthcare Settings

DOH | Immunization

DOH | What To Do When You Are Sick With COVID-19 Or Another Respiratory Viruses

Washington State Voluntary use of PPE, WAC 296-800-16080

Washington State Safety Standards for Respirators, Chapter 296-842 WAC

CDC | Healthcare Infection Control Practices Advisory Committee (HICPAC)

CDC | Infection Control Guidance: SARS-CoV-2

CDC | Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States

CDC | Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2

CDC | Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings

CDC | NIOSH Personal Protective Equipment

CDC | NIOSH Respirators and Mask Types and Performance

References

Bansal, A., Trieu, M.-C., Eriksson, E. M., Zhou, F., McVernon, J., Brokstad, K. A., & Cox, R. J. (2025). SARS-CoV-2 infection rates and associated risk factors in healthcare workers: Systematic review and meta-analysis. Scientific Reports, 15(4705). https://doi.org/10.1038/s41598-025-89472-5

Blachere, F. M., Lemons, A. R., Coyle, J. P., et al. (2022). Face mask fit modifications that improve source-control performance. American Journal of Infection Control, 50(2), 133-140. https://doi.org/10.1016/j.ajic.2021.10.041

Healthcare Infection Control Practices Advisory Committee (HICPAC). (2024). HICPAC meeting minutes, November 14-15 2024. Atlanta, Georgia. Centers for Disease Control and Prevention, U.S. Department of Health & Human Services. https://www.cdc.gov/hicpac/media/pdfs/2024-November-HICPAC-Summary-508.pdf

Lai, J. Y., Coleman, K. K., Tai, S. S., et al. (2024). Relative efficacy of masks and respirators as source control for viral aerosol shedding from people infected with SARS-CoV-2: A controlled human exhaled-breath experimental study. eBioMedicine, 104, 105-157. https://doi.org/10.1016/j.ebiom.2024.105157

Leung, N. H. L., Chu, D. K. W., Shiu, E. Y. C., et al. (2020). Respiratory virus shedding in exhaled breath and efficacy of face masks. Nature Medicine, 26(5), 676-680. https://doi.org/10.1038/s41591-020-0843-2

Lindsley, W. G., Blachere, F. M., Law, B. F., et al. (2021). Efficacy of face masks, neck gaiters and face shields for reducing the expulsion of simulated cough-generated aerosols. Aerosol Science and Technology, 55(4), 449-457. https://doi.org/10.1080/02786826.2020.1862409

MacIntyre, C. R., Zhang, Y., Chughtai, A. A., et al. (2016). Cluster randomised controlled trial to examine medical mask use as source control for people with respiratory illness. BMJ Open, 6(12), e012330. https://pmc.ncbi.nlm.nih.gov/articles/PMC9345365/

Mäkelä, E. A., Jussila, K., & Laitinen, S. (2024). *Effectiveness of masks and respirators against respiratory infections*. Finnish Institute of Occupational Health. https://www.julkari.fi/handle/10024/149933

Milton, D. K., Fabian, M. P., Cowling, B. J., et al. (2013). Influenza virus aerosols in human exhaled breath: Particle size, culturability, and effect of surgical masks. PLOS Pathogens, 9(3), e1003205. https://doi.org/10.1371/journal.ppat.1003205

Popa, M. V., Gurzu, I. L., Mîndru, D. E., Gurzu, B., Handra, C. M., Eva-Maria, E., Olaru, I., Anton-Păduraru, D. T., Warter, C., & Duceac, L. D. (2025). Dynamics of absences due to respiratory infections, including COVID-19, among medical staff in a regional pediatric hospital. Healthcare, 13, 563. https://doi.org/10.3390/healthcare13050563

Wight, E., Swift, M., O'Horo, J. C., Hainy, C., Molella, R., Morrow, A., & Breeher, L. (2022). COVID-19 infections in health care personnel by source of exposure and correlation with community incidence. Journal of Occupational and Environmental Medicine, 64(8), 675-678. https://doi.org/10.1097/JOM.0000000000002562

Yang, W., Myers, W. R., Bergman, M., Fisher, E., Ryan, K. J., Vollmer, B., Portnoff, L., & Zhuang, Z. (2025). Evaluating source control efficacy against exhaled submicron particles: Total outward leakage of surgical masks and half facepiece respirators across a spectrum of particle sizes. Aerosol Science and Technology, 59(4), 487-498. https://doi.org/10.1080/02786826.2024.2427282

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