

COVID-19 Recommendations for Health Care Workers

9/29/2021

This guidance was updated on Sept. 29, 2021, to include:

- All health care workers, regardless of vaccination status, should be tested for SARS-CoV-2 when symptomatic after a higher-risk exposure and when working in a facility experiencing an outbreak.
- Post-exposure testing should occur immediately upon identification of the case (but not earlier than two days after exposure) and at day five to seven after exposure.

Testing of health care workers for COVID-19

- Health care workers (HCWs) should not work while sick, even if presenting with mild signs or symptoms. HCWs with fever and/or respiratory symptoms that are concerning for COVID-19 should be tested for SARS-CoV-2 as soon as possible. HCWs who have had unprotected exposure to a person with confirmed COVID-19, but who remain asymptomatic, should be tested immediately upon identification of the case (but not earlier than two days after exposure) and five to seven days following the date of exposure, at a minimum.

Specific routine staff testing is required or recommended by federal and/or state guidelines in skilled nursing or assisted living facilities. Please refer to [Long-Term Care Testing: COVID-19 \(www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html) for detailed testing recommendations, which have been updated to discuss recommendations for vaccinated HCWs.

Health care workers with exposure to COVID-19

MDH and health care organizations cooperate to identify, manage, and monitor HCWs who have experienced a high-risk (unprotected) exposure to a patient, resident, coworker, or household/social contact with confirmed COVID-19. Most HCWs who have had a high-risk exposure are identified through occupational tracking of personal protective equipment (PPE) breaches and/or contact tracing and assessment of PPE worn while in contact with a COVID-19-positive patient, resident, or coworker. HCWs with high-risk exposures are also identified through MDH COVID-19 case interviews and self-report.

Fully vaccinated health care workers

Fully vaccinated HCWs with high-risk exposures who remain asymptomatic do not need to quarantine from work or the community for the 14 days following their exposure. HCWs are considered fully vaccinated two weeks after their final COVID-19 vaccine dose (two doses in a two-dose series or one dose in a one-dose series). Work restriction for 14 days should still be considered for:

- HCWs who have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which may impact the level of protection provided by the COVID-19 vaccine. Data on which immunocompromising conditions may affect response to the COVID-19 vaccine, and the magnitude of risk, are not available.
- HCWs who have had a high-risk exposure should be proactively tested post-exposure, immediately upon identification of the case (but not earlier than two days after exposure), and between days five and seven post-exposure. HCWs who return to work in that time must wear a medical-grade facemask for source control at all times. If signs or symptoms develop at any time in the 14 days following exposure, HCWs should seek testing and isolate at home.
- Fully vaccinated asymptomatic HCWs may be exempt from expanded screening testing in health care facilities (e.g., routine staff testing in long-term care facilities).
- Fully vaccinated HCWs should have a SARS-CoV-2 test if symptomatic after a higher-risk exposure, or when working in a facility experiencing an outbreak.

In rare situations, MDH may recommend quarantine of a fully vaccinated HCW after exposure to a newly recognized variant of concern or variant of high consequence. CDC continues to evaluate the impact of vaccination and the emergence of novel SARS-CoV-2 variants on health care infection prevention and control recommendations.

- [CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic \(www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)

Unvaccinated health care workers

These recommendations are relevant for unvaccinated HCWs (all HCWs who do not meet the fully vaccinated criteria above) who have had a high-risk workplace exposure to COVID-19 and for HCWs with household, intimate, or close community contacts who have confirmed or suspected COVID-19.

- HCWs should quarantine from work for 14 days following a high-risk exposure.
- HCWs might consider temporarily moving into alternative accommodations, if available, to maintain distance from an ill household member and shorten the time needed to be excluded from work. The quarantine period does not begin until the last date of unprotected exposure to the test-positive household member. Given family and caregiver responsibilities, this will not be feasible for many HCWs.
- HCWs who have had a high-risk exposure should be proactively tested post-exposure (e.g., immediately upon identification of the case, but not earlier than two days after exposure, and again between days five and seven post-exposure). If signs or symptoms develop at any time in the 14 days following exposure, the HCWs should seek testing and isolate at home.

As a component of the contingency staffing plan, if a health care facility has exhausted all other staffing options and is experiencing a staffing shortage, asymptomatic HCWs who have experienced a high-risk exposure but who have not tested positive for COVID-19 may be asked to return to work during the voluntary quarantine period (see below). HCWs who return to work in that time must wear a medical-grade facemask for source control at all times.

Facilities may consider asking exposed HCWs to return when a staffing shortage persists even despite systemic implementation of other means of filling shifts (for example: bonuses; leadership assisting with direct patient care; 12-hour shifts versus eight-hour shifts; hazard pay; reducing non time-sensitive procedures, etc.). HCWs who have experienced a high-risk exposure are protected under Minnesota Statutes, section 144.4196, which provides worker protections to those asked by MDH to stay out of work because of exposure to, or infection with, an infectious disease. As such, these exposed HCWs can choose whether to return to work during the recommended quarantine period.

Unvaccinated HCWs should remain out of work for 14 days but may return to community activities based on the quarantine options outlined in the community quarantine guidance. Specifically, HCWs must be asymptomatic (not ill), not have a positive SARS-CoV-2 test, and have a defined exposure with a specific date of last exposure. Exposed HCWs must continue to self-monitor for signs and symptoms of COVID-19 through day 14. If signs or symptoms develop at any time during the 14-day period, HCWs should seek testing and isolate at home.

- [Quarantine Guidance for COVID-19 \(www.health.state.mn.us/diseases/coronavirus/quarguide.pdf\)](http://www.health.state.mn.us/diseases/coronavirus/quarguide.pdf)

Travel recommendations for health care workers

Travel increases your chances of becoming infected and transmitting SARS-CoV-2. CDC and MDH recommend that unvaccinated people do not travel at this time. Delay travel and stay home to protect yourself and others from COVID-19.

CDC has outlined considerations for travel (e.g., transportation, accommodation, activities), and potential associated risk. Health care organizations should review CDC resources to establish expectations for HCWs around travel, and the course of action (e.g., testing, 14-day quarantine) that will be taken for HCWs who participate in nonessential travel.

- [CDC: Public Health Guidance for Potential COVID-19 Exposure Associated with Travel \(www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html\)](https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html)

For more recommendations and things to consider before, during, and after travel, visit:

- [Protect Yourself & Others: Traveling \(www.health.state.mn.us/diseases/coronavirus/prevention.html#travel\)](http://www.health.state.mn.us/diseases/coronavirus/prevention.html#travel)
- [CDC: Safer Travel Tips for Families with Unvaccinated Children \(www.cdc.gov/coronavirus/2019-ncov/travelers/travel-risk.html\)](https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-risk.html)

Standards for bringing health care workers back to work after experiencing a high-risk exposure

Health care facilities experiencing acute staffing shortage should have a systemic crisis staffing plan in place that systematically addresses all other options (for example, bonuses; leadership assisting with direct patient care; 12-hour shifts versus eight-hour shifts; hazard pay; reducing non time-sensitive procedures) to obtain staff prior to considering the return of HCWs who are in quarantine after experiencing a high-risk exposure to a person with COVID-19, as long as these HCWs are not experiencing symptoms and are not infectious (i.e., have not recently tested positive) with COVID-19. These HCWs should be brought back to work using the following standards. **This information does not pertain to asymptomatic SARS-CoV-2-positive HCWs, who should be excluded from the workplace until they meet return-to-work criteria for individuals with COVID-19.**

1. Worker protections are established in state isolation and quarantine statutes, and HCWs who have experienced a high-risk exposure cannot be forced to return to work during the quarantine period. If HCWs choose not to return to work, Minnesota Statutes, section 144.4196 protects them from retaliation.
2. Different types of high-risk exposures carry different risks of testing positive for COVID-19. Therefore, facilities should ask exposed HCWs to return to work in the following order. All HCWs from one group should be asked to return prior to bringing back HCWs from the next group. Facilities should also take into account specialty-specific or unit-specific needs when asking HCWs with high-risk exposures to return.
 - a. Unvaccinated (or not fully vaccinated) HCWs with occupational high-risk exposure to a patient, resident, or coworker.
 - b. Unvaccinated (or not fully vaccinated) HCWs with recent return from nonessential travel. If travel was by private car, consistent prevention measures were used, and HCWs stayed only with household members, they may be brought back before HCWs with known occupational exposure.
 - c. Unvaccinated (or not fully vaccinated) HCWs with high-risk exposure to a social contact.
 - d. Unvaccinated (or not fully vaccinated) HCWs with high-risk exposure to a household member; HCWs with a household exposure should return only if able to isolate from the test-positive household member.
3. Exposed HCWs who return during quarantine should take on a role that does not have direct patient care duties (e.g., telemedicine, phone triage), when feasible.
4. If it remains necessary for HCWs to provide direct patient care during the quarantine period, the HCWs should:
 - a. Avoid seeing high-risk patients (e.g., older adults, immunocompromised people, and those with comorbidities), if possible.
 - b. Practice diligent hand hygiene and wear a medical-grade facemask at all times.
 - c. Avoid sharing break room or lunchroom with coworkers.
 - d. Monitor themselves closely for any symptoms associated with COVID-19 (e.g., measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or loss of taste or smell), and measure body temperature daily before going to work.
 - e. Remain at home and notify their supervisor if they develop respiratory symptoms OR have a measured body temperature higher than 100 degrees Fahrenheit.

- f. If at work when fever or respiratory symptoms develop, immediately notify their supervisor and go home.
 - g. Notify their supervisor of other symptoms (e.g., fever higher than 100 degrees Fahrenheit, nausea, vomiting, diarrhea, abdominal pain, runny nose, fatigue), as medical evaluation may be recommended.
5. HCWs who have had a high-risk exposure and return to work during quarantine should be proactively tested post-exposure. Specific testing protocols are dependent on the health care facility testing capacity and turnaround time. At a minimum, MDH recommends that exposed HCWs who work during the 14-day quarantine period be tested immediately upon identification of the case (but not earlier than two days after exposure) and if negative, between days five and seven following the date of the high-risk exposure.
 6. HCWs should consider a midshift self-assessment for signs and symptoms of COVID-19 while working during quarantine.
 7. Facilities should increase audits for PPE, hand hygiene, and activity in break rooms and lunchrooms, and limit the number of HCWs in break rooms to ensure social distancing. HCWs working during a quarantine period should take breaks alone in the break room, if possible.
 8. Facilities should establish a higher level of awareness for potential SARS-CoV-2 spread within the facility, following recommendations from MDH for assessment of clusters of individuals (patients, residents, HCWs) who have symptoms or who have tested positive. Maintain a low threshold for investigating increases in staff calling in sick and for observing fatigue in using personal protective equipment in areas such as break rooms.

Data to inform return to work for exposed health care workers

Analysis of data from exposure risk assessments and post-exposure monitoring of HCWs has shown that not all high-risk exposures are equal. HCWs who experience a high-risk exposure in the household or social setting are much more likely to test positive in the following 14 days. During October 2020, 15.5% of acute care HCWs with high-risk exposures to test-positive household or social contacts tested positive during the 14 days following exposure. In contrast, only 1.6% of acute care HCWs with high-risk exposures to a patient, and 3.6% of HCW exposed to a coworker, tested positive in the next 14 days. Similar disparities between outcomes of occupational and nonoccupational exposures exist for congregate care settings.

Management of staffing shortages

Health care facilities may continue to experience staffing shortages despite recalling asymptomatic HCWs who experienced a high-risk exposure but have not tested positive for COVID-19. Refer to the following guidance for additional staffing considerations.

- [Clarification of Staffing Options for Congregate Care Facilities Experiencing Staff Shortages \(www.health.state.mn.us/diseases/coronavirus/hcp/staffoptions.html\)](http://www.health.state.mn.us/diseases/coronavirus/hcp/staffoptions.html)
- [Defining Crisis Staffing Shortage in Congregate Care Facilities: COVID-19 \(www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html\)](http://www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html)

Guidance for ill health care workers with confirmed or suspected COVID-19

As recommended above, HCWs who become ill with respiratory symptoms OR fever (higher than 100 degrees Fahrenheit) should communicate with their supervisor and stay out of work. HCWs with this clinical presentation are considered to have a suspected or confirmed (with laboratory testing) diagnosis of COVID-19. CDC has provided return to work criteria: [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 \(Interim Guidance\) \(www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html). A symptom-based strategy is recommended and includes:

- HCWs with mild to moderate illness who are not severely immunocompromised:
 - At least 24 hours have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath); AND,
 - At least 10 days have passed since symptoms first appeared.
 - Practice of diligent hand hygiene and wearing a medical-grade facemask at all times until 14 days after illness onset.
- HCWs with severe to critical illness or who are severely immunocompromised:
 - At least 24 hours have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath); AND,
 - At least 20 days have passed since symptoms first appeared.

A test-based strategy is not recommended to determine when to allow HCWs to return to work but could be considered in specific situations to allow the HCWs to return to work sooner than the symptom-based strategy.

Asymptomatic HCWs with laboratory-confirmed COVID-19 should be excluded from work for 10 days following specimen collection. HCWs who are severely immunocompromised but remain asymptomatic throughout their infection should be excluded from work for 20 days following specimen collection. If these individuals subsequently develop symptoms since their positive test, their return to work should be guided by the recommendations for confirmed COVID-19, above.

HCWs who present to work or screen positive with cold or flu symptoms should leave work immediately and be tested for COVID-19 using RT-PCR. If a HCW does not get tested or tests **positive**, follow the COVID-19 work exclusion and isolation guidance outlined above. If a HCW tests **negative** and is still experiencing symptoms, the HCW should follow the guidance below:

- If persistent symptoms are consistent with an established chronic health condition, the HCW may return to work after consultation with their manager and occupational health department. Evaluation of acute symptoms by a health care provider may also be indicated.
- If persistent symptoms are not consistent with a known chronic health condition, the HCW should be evaluated by a health care provider.
 - If the health care provider provides an alternate diagnosis, criteria for return to work should be based on that diagnosis.
- If the health care provider does NOT provide an alternate diagnosis and the HCW does NOT have a known high-risk exposure to a person with confirmed COVID-19, the HCW should remain isolated and not return

to work until at least 24 hours have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath).

- If the health care provider does NOT provide an alternate diagnosis and the HCW does have a known high-risk exposure, the HCW should obtain a second SARS-CoV-2 RT-PCR test. The HCW should remain isolated until the test results are known. Minnesota continues to experience high levels of community transmission, and the potential consequences of working with COVID-19 are serious.
 - If positive, follow the COVID-19 work exclusion and isolation guidance outlined above.
 - If negative, the HCW can return to work following the test-based strategy if at least 24 hours have passed since resolution of fever and symptoms are improving.

HCWs who experience symptoms following vaccination for SARS-CoV-2:

- Systemic signs and symptoms, such as fever, fatigue, headache, chills, myalgia, and arthralgia, can occur following COVID-19 vaccination. Facilities should refer to [CDC: Post-vaccination Considerations for Workplaces \(www.cdc.gov/coronavirus/2019-ncov/community/workplaces-businesses/vaccination-considerations-for-workplaces.html\)](https://www.cdc.gov/coronavirus/2019-ncov/community/workplaces-businesses/vaccination-considerations-for-workplaces.html) for guidance on evaluation and work exclusion for HCWs who experience symptoms following vaccination.

Guidance for recovered health care workers who are exposed to COVID-19 positive patients

HCWs with past confirmed COVID-19 infection should return to work based on the symptom-based strategy recommended above. Within three months of COVID-19 symptoms starting or of a positive RT-PCR test for SARS-CoV-2, an asymptomatic HCW with a high-risk exposure to a confirmed COVID-19-positive person does not need to be quarantined or retested but should self-monitor for symptoms consistent with COVID-19. If symptoms develop, the exposed HCW should be assessed and potentially tested for SARS-CoV-2, if an alternate etiology is not identified. However, if the HCW has a high-risk exposure to a confirmed case three months or more after onset of their initial illness, the HCW should follow the quarantine and work exclusions outlined above.

MDH does not currently recommend using serological tests to determine whether previously infected HCWs can continue to work after experiencing a new exposure to a person with COVID-19. There are currently insufficient data regarding immunological response and protective immunity after COVID-19 infection. Because the interval between resolution of illness and development of any protective immunity is also unknown, viral carriage and transmission to others during this period cannot be ruled out.

Guidance for communal activities among health care workers within a health care setting

Unvaccinated and fully vaccinated HCWs should continue to wear a medical-grade facemask and eye protection while at work for source control and maintain appropriate physical distancing while interacting with coworkers, and follow the recommended Transmission-Based Precautions while caring for patients or residents.

CDC has outlined considerations for health care facilities to allow HCWs to gather without source control or physical distancing if all present are fully vaccinated and the facility is located in a county with low to moderate

community transmission. MDH does not have specific recommendations on this topic. Medical and legal leadership should develop health care facility-specific protocols and procedures, which may or may not include the relaxation of source control and distancing outlined by CDC for fully vaccinated HCWs.

- [CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic \(www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)
- [CDC COVID Data Tracker: COVID-19 Integrated County View \(https://covid.cdc.gov/covid-data-tracker/#county-view\)](https://covid.cdc.gov/covid-data-tracker/#county-view)

CDC considerations for allowing HCWs to gather without source control or physical distancing include:

- The health care facility is located in a county with low to moderate community transmission, as defined by CDC.
- Vaccination status of those present. Fully vaccinated HCWs can dine and socialize together in break rooms and conduct in-person meetings without source control or physical distancing as long as no unvaccinated HCWs are present
 - If unvaccinated HCWs are present, all HCWs should wear source control, and unvaccinated HCWs should physically distance.

Definitions

Using CDC's COVID Data Tracker (<https://covid.cdc.gov/covid-data-tracker/#county-view>): The tracker uses two different indicators (total new cases and test percent positivity) to determine the level of SARS-CoV-2 transmission for the county where the health care facility is located. The four levels are low, moderate, substantial, and high. If the two indicators suggest different transmission levels, the tool defaults to the higher level.

The following definitions are from [CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic \(www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).

SARS-CoV-2 illness severity criteria were adapted from National Institutes of Health COVID-19 Treatment Guidelines.

Mild illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO₂) greater than or equal to 94% on room air at sea level.

Severe illness: Individuals who have respiratory frequency of more than 30 breaths per minute; SpO₂ less than 94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of more than 3%); ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO₂/FiO₂) less than 300 mmHg; or lung infiltrates greater than 50%.

Critical illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.

Severely immunocompromised: For the purposes of this guidance, CDC used the following definition:

- Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count less than 200, combined primary immunodeficiency disorder, and receipt of prednisone more than 20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions.
- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Resources

- [CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic \(www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)
- [CDC: Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 \(www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html)
- [CDC: Ending Isolation and Precautions for People with COVID-19: Interim Guidance \(www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html)
- [CDC: Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States \(www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html\)](https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html)
- [Defining Crisis Staffing Shortage in Congregate Care Facilities: COVID-19 \(www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html)
- [Clarification of Staffing Options for Congregate Care Facilities Experiencing Staff Shortages \(www.health.state.mn.us/diseases/coronavirus/hcp/staffoptions.html\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/staffoptions.html)
- [CDC: Strategies to Mitigate Healthcare Personnel Staffing Shortages \(www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html)
- [CDC: If You Are Sick or Caring for Someone \(www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/index.html\)](https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/index.html)
- [Rapid IgM/IgG SARS-CoV-2 Tests \(www.health.state.mn.us/diseases/coronavirus/hcp/sarscov2test.pdf\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/sarscov2test.pdf)
- [Long-term Care Testing: COVID-19 \(www.health.state.mn.us/diseases/coronavirus/hcp/lctesting.html\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/lctesting.html)



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