SICKNESS ABSENCE FORM

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| Name: | Department: |
| Date of first day of sickness absence |  |
| Date of the last day of sickness absence |  |
| Date of return to work |  |
| Could your absence have been due to a work-related injury/condition? (yes/no) |  |
| Has an accident report form been completed? (yes/no) |  |
| Is the absence related to a previous absence? (yes/no) |  |
| Details of Sickness or Injury --------------------------------------------------------------------------------------------------------------------------------------------------------- --------------------------------------------------------------------------------------------------------------------------------------------------------- --------------------------------------------------------------------------------------------------------------------------------------------------------- --------------------------------------------------------------------------------------------------------------------------------------------------------- |
| Did you consult a Medical Practitioner? YES / NO. If YES, please give details of:Doctor’s Name, Address, Date of Visit. |
| DeclarationI certify that I have been incapable of work because of my sickness/injury on the date shown above and that this information is true and accurate. I am now fit to work.I acknowledge that false information will result in disciplinary action.I hereby give my employer permission to verify the above information.Signed (employee): ………………………………………… Manager: ………………………………………………..Date:  |

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| Manager’s notes: |