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. | | | |
| Declaration I 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: |