SICKNESS SELF–CERTIFICATION ABSENCE FORM

This form should be completed on your return to work following any period of sickness.

If you are off work due to sickness for up to 7 days, the weekend is included.

If you are returning to work after a period of sickness of **more than 7 calendar days** a medical certificate or certificates should already have been provided to cover the period of absence in excess of these first seven days.

Name:			
Dates of Absence	**Day**	**Date**	**Time**
First date of absence:			am/pm
Last date of absence:			am/pm
Date of return to work:			am/pm
Total number of days sick:			
Details of sickness or injury:			
Did you consult a Doctor?	No ☐	Yes ☐	Date of visit:
If yes please give details of:	Doctors name:	Address:	
Details of any treatment received and any current treatment:			

Declaration

I certify that I was incapable of work because of my sickness/injury on the dates shown above and that this information is true and accurate.

- I acknowledge that false information will result in disciplinary action.
- I hereby give my employer permission to verify the above information.

Signed _____ **Acknowledged** _____

Employee Employer

Date _____