

**SICKNESS SELF-CERTIFICATE ABSENCE FORM**

This form should be completed on your return to work following any period of sickness. If you are returning to work after a period of sickness of **more than seven calendar days** a medical fit note should already have been provided to cover the period of absence in excess of these first seven days.

For certification purposes, an absence that starts and finishes either side of non-working days is assumed to include those non-work days (e.g. weekends, public holidays and, for part-time employees, days on which they would not usually work).

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| --- | --- | --- | --- | --- | --- |
| **Personal Details** | | | | | |
| **Name:** |  | | | | |
| **Dates of Sickness (including non-working days)** | | | | | |
| **Start Date** | **Date:** | **End Date** | | | **Date:** |
| **Time:** | **Time:** |
| **Details of Sickness Injury** | | | | | |
| **Details of sickness / injury:** |  | | | | |
| **Did you consult a Doctor (please tick)** | | | | | |
| **YES NO** | | | | | |
| If **YES** please give details of: treatment received and any current treatment. | | | | | |
| **Declaration (please read this carefully before signing this form)** | | | | | |
| 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. | | | | | |
| **Employee Signed:** |  | | **Date:** |  | |
| **Manager Signed:** |  | | **Date:** |  | |