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| EMPLOYEE ABSENCE SELF CERTIFICATION FORM |
| Employees must complete this form and send it to their line manager as required by the Absence Management Policy |

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| EMPLOYEE / MANAGER DETAILS | |
| Employee Name: |  |
| Department: |  |
| Manager Name: |  |

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| ABOUT YOUR ILLNESS or INJURY | |
| When did you first become ill (date and approx. time)? |  |
| On what date were you first absent from work? |  |
| On what date did you return to work? |  |
| How many working days were you absent for? |  |
| Describe the illness or injury that caused you to be absent: |  |

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| MEDICAL ATTENTION | |
|  | Delete as appropriate |
| Did you consult with your G.P. or another medical practitioner? | Y/N |
| Did you attend a hospital or doctors’ clinic? | Y/N |
| Did you obtain medication for your condition? | Y/N |

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| EMPLOYEE WELLBEING QUESTIONS | |
| Are you taking medication that may have an effect on your ability to undertake your duties? | Y/N |
| Do you have a long term health condition that caused or contributed to your absence? | Y/N |
| If you are female, was your absence related to pregnancy? | Y/N |
| Was your absence because of an accident at work or some other work related factor? | Y/N |
| If you have answered ‘yes’ to any of the questions above please provide such further details as you feel are appropriate below: | |
| <Type here> | |

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| DECLARATION | | | |
| The persons below insert their initials and the date they reviewed this form to confirm the accuracy of the information recorded: | | | |
| Employee’s initials: |  | Date: |
| Manager’s initials: |  | Date: |

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| (THIS SECTION IS FOR THE MANAGER TO COMPLETE) - RETURN TO WORK MEETING | | |
| Has a return to work meeting taken place? | Y/N |
| If a return to work meeting is ***not*** required, please explain why: |  |