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| RETURN TO WORK MEETING FORM |
| A return to work meeting should take place if the employee’s absence is long term, persistently intermittent, or where an employee wellbeing issue may be relevant. The manager completes this form. |

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

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| THE ABSENCE | |
| Has the employee provided a Self-Certification Form (and for any absence of 7 days or more, a G.P. Fit Note)? | Y/N |
| Was the absence short term (i.e. less than 1 week in duration)? | Y/N |
| Is it clear that the absence is ***not*** part of a recurring pattern of similar absences? | Y/N |
| Is the reason for absence given on the Employee Self-Certification Form clear and understandable? | Y/N |
| Did the employee follow the absence reporting procedure/s as required? | Y/N |
| ‘NO’ ANSWERS – if the answer to any of the questions above is ‘no’ please provide details below: | |
| <Type here> | |

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| EMPLOYEE WELLBEING | |
| Is there any reason to believe the absence was caused by: | |
| A long-term health condition? | Y/N |
| Pregnancy? | Y/N |
| A work-related accident? | Y/N |
| Some other work related factor (e.g. stress)? | Y/N |
| ‘YES’ ANSWERS – if the answer to any of the questions above is ‘yes’ please provide details below: | |
| <Type here> | |

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| FITNESS FOR WORK AND ADJUSTMENTS | |
| Is the employee now fully fit for work? | Y/N |
| Is anything *work related* causing difficulties? | Y/N |
| If so: is there something that can be done to reduce or remove the difficulties identified? | Y/N |
| And can additional support be provided to assist the employee? | Y/N |
| What adjustment/s or support should be considered? | |
| <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 above:  ***Please note:*** if either person disagrees with the accuracy of information they must raise this in writing to the other without delay. | | | |
| Employee’s initials: |  | Date: |
| Manager’s initials: |  | Date: |

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| (THIS SECTION IS FOR THE MANAGER TO COMPLETE) – POSSIBLE FURTHER ACTION | | |
| Should formal absence management procedure under the Absence Management Policy be considered? | Y/N |
| Would a medical referral be helpful to obtain advise about the underlying cause of absence/s and possible measures to assist? | Y/N |