SICKNESS SELF-CERTIFICATION

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 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 sickness (Including non-working days)

FROM	**TO**
_____ **am/pm**	_____ **am/pm**
_____ **day**	_____ **day**
_____ **date**	_____ **date**

Dates of absence

FROM	**TO**
_____ **am/pm**	_____ **am/pm**
_____ **day**	_____ **day**
_____ **date**	_____ **date**

Details of sickness or injury

Did you consult a Doctor? YES/NO. If YES please give details of: Doctor's name, address, date of visit, treatment received and any current treatment. If NO please state why not.

Declaration

I certify that I was incapable of work because of my sickness/injury on the dates shown 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 _____ (employee) **Acknowledged _____ (for employer)**

Date _____