

**SELF CERTIFICATION OF SICKNESS ABSENC**

To be completed following your return to work in respect of sickness absences lasting 0.5 to 7 days only. Any sickness absence over 7 days must be covered by a Statement for Fitness for Work from your GP or equivalent documentation from a hospital. If your absence includes a Saturday or Sunday this should be included in your period of absence. Once completed please forward to Human Resources, Z3-046, Services and Administration Centre, Eagle Campus.

**Personal Details**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title: | ………………………… | | Surname: | | | | ………………………………………………………………………………….. | | | | |
| Forename(s): | | | ………………………………………………………………………………………………………………….. | | | | | | | | |
| Job Title: | | | ………………………………………………………………………………………………………………….. | | | | | | | | |
| School/Service: | | | ………………………………………………………………………………………………………………….. | | | | | | | | |
| Employee Number: | |  | |  |  |  | |  |  |  |  | |

**Period of Absence**

|  |  |  |
| --- | --- | --- |
|  | **am/pm/all day** | **Day/Date** |
| When was the first working day you were absent due to sickness? |  |  |
| When was the first day you were fit to return to work? |  |  |
| When was the first day you actually returned to work? |  |  |

**Details of Sickness**

|  |
| --- |
| Reason(s) for sickness absence *(please be as specific as possible)*: |

In addition, please also tick 🗹 one appropriate category below for monitoring purposes:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Anxiety/Stress/Depression | 🞏 | Back Problems | 🞏 | Blood Disorders | 🞏 |
| Burns/Poisoning/Frostbite | 🞏 | Cancers – Benign and Malignant | 🞏 | Chest and Respiratory Problems | 🞏 |
| Cough, Cold and Flu | 🞏 | Dental and Oral Problems | 🞏 | Ear, Nose and Throat (ENT) | 🞏 |
| Endocrine and Glandular | 🞏 | Eye Problems | 🞏 | Gastrointestinal | 🞏 |
| General Debility | 🞏 | Genitourinary and Gynaecological | 🞏 | Headache/Migraine | 🞏 |
| Heart, Cardiac and Circulatory Problems | 🞏 | Infectious Diseases | 🞏 | Injury/Fracture | 🞏 |
| Nervous System Disorder | 🞏 | Other musculoskeletal | 🞏 | Post-Operative Recovery | 🞏 |
| Pregnancy Related | 🞏 | Skin Disorder | 🞏 | Substance Abuse | 🞏 |

**PTO**

If you are a part-time employee, please indicate 🗹 which days would have been your normal working days during the period of sickness absence. This information is required to ensure calculation of the correct Occupational Sick Pay entitlements.

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Mon: | 🞏 | Tues: | 🞏 | Wed: | 🞏 | Thurs: | 🞏 | Fri: | 🞏 |

Please indicate whether you think that your sickness absence was due to an accident at work or an industrial disease. Please tick 🗹 the relevant box, if applicable.

|  |  |  |  |
| --- | --- | --- | --- |
| Accident at Work | 🞏 | Industrial Disease | 🞏 |

**Declaration**

I declare that I was unable to work during the period of sickness I have stated overleaf. I declare that the details given by me are, to the best of my knowledge, correct and I understand that any deliberate false declaration may result in disciplinary action.

Signed:……………………………………………………………………………………. Date: ……………………………………………………………………..

**To be completed by the Line Manager:**

|  |  |
| --- | --- |
| Line Manager Name: | ………………………………………………………………………………………………………………….. |
| Job Title: | ………………………………………………………………………………………………………………….. |
| School/Service: | ………………………………………………………………………………………………………………….. |

**Details of Return to Work Arrangements**

Date of Meeting……………………………………………………………………………………………………………………………………………….

|  |
| --- |
| Please provide details of any return to work arrangements agreed with the Employee: |

Signed:……………………………………………………………………………………. Date: ……………………………………………………………………..

(Line Manager)