SELF-CERTIFICATION OF ABSENCE

This form is to be completed by the employee on his/her first day of return to work. Where information is required, please be as accurate as possible.	
Personal Details	
Full Name:	
Employee Number:	
Job Title:	
Department:	Site:
Details of Absence	
Date of absence: From:	To:
Total number of working days absent:	
Reason(s) for absence *(to be completed for all absences)*	
Was your absence due to a work related accident? YES ☐ NO ☐ If so, who did you report this to?	
Did you consult a Medical Practitioner during your absence? YES ☐ NO ☐	
Are you continuing to undergo treatment or taking any medication which may affect your ability to do your job? YES ☐ NO ☐ *If yes, please give details.*	
Do you consider that you have a disability (as defined by the DDA)? YES ☐ NO ☐ Is the absence because of your disability? YES ☐ NO ☐	
Declaration	
I declare the above information is true and accurate. I understand that knowingly giving false information on this form will result in disciplinary action and may affect any entitlement to SSP/ contractual sick pay.	
Employee Signature:	Date: