

EMPLOYEE SICKNESS ABSENCE SELF-CERTIFICATE

Name	<input type="text"/>
	<input type="text"/>
Job title	<input type="text"/>
A. PERIOD OF ABSENCE	
Date and time illness began (including non-working days)	<input type="text"/>
Date fit for work (including non-working days)	<input type="text"/>
First notification to (give date, time and method of notification, and name of person notified)	<input type="text"/>
Total number of working days absent (include Bank Holidays)	<input type="text"/>
B. DETAILS OF SICKNESS ABSENCE	
Reason for absence (please give details)	<input type="text"/>
Personal Sickness <input type="checkbox"/> Injury Sustained at Work <input type="checkbox"/> Maternity Related Sickness <input type="checkbox"/>	
Please describe symptoms	<input type="text"/>
C. DETAILS OF TREATMENT	
Did you see a doctor or attend a hospital or clinic?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, give name and address	<input type="text"/>
Please state the treatment or medication given	<input type="text"/>
If no, please describe any self-prescribed treatment or medication	<input type="text"/>
If you are still away from work due to illness when are you likely to be fit for work?	<input type="text"/> (return date)
I understand that if I provide false or misleading information about my absence it may, depending on the circumstances, be treated as gross misconduct and result in my summary dismissal.	
Employee's signature	<input type="text"/>
Date	<input type="text"/>
Manager's signature	<input type="text"/>
Date	<input type="text"/>

Once completed please return this form as soon as possible to your Line Manager