**SICKNESS DECLARATION FORM**

On your return to work, this form must be completed in full immediately and returned to your manager for submission to the Absence Admin Team. Not doing so may result in delayed pay.

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Member of staff details** | | | | | | | | | | | | |
| **\***First and last name: | | | | | | | | Date of Birth: | | | | |
| **\***Department and division: | | | | | | | | NI Number: | | | | |
| \*Manager/Supervisor | | | | | | | | \*Personal Ref No.  (Required Field) | | | | |
| **Sickness absence details** | | | | | | | | | | | | |
| **\***First date of sickness absence | | Date | | | | | | | | | | |
| **\***Last date of sickness absence | | Date | | | | | | | | | | |
| **\***Total number of working days absent | | | | |  | **\***Total number of working hours absent (Health & Social Care staff only) | | | | |  | |
|  | | | | | | | | | | | | |
| **\***Please tick **ONE** box in the list below which best describes the reason for this sickness absence | | | | | | | | | | | | |
| Dental | | | | |  | Neurological | | | | |  | |
| Cancer | | | | |  | Diarrhoea and/or vomiting | | | | |  | |
| Chest, respiratory | | | | |  | Stomach, digestive | | | | |  | |
| Infection or virus | | | | |  | Operation, hospitalisation | | | | |  | |
| Flu, cold symptoms | | | | |  | Pregnancy related | | | | |  | |
| Migraine or headache | | | | |  | Gynaecological or andrological | | | | |  | |
| Musculoskeletal | | | | |  | Stress, anxiety, depression: work related | | | | |  | |
| Heart, circulation or blood pressure | | | | |  | Stress, anxiety, depression, grief reaction: personal | | | | |  | |
| Glandular | | | | |  | Diagnosis unclear | | | | |  | |
| Other: please specify | | | | |  | | | | | | | |
| **Secondary employment** | | | | | | | | | | | | |
| Have you undertaken any secondary employment during this period of sickness absence? | | | | | | | | | | YES / NO | | |
| If YES | What dates did you work? | | | Dates | | | | | | | | |
| Was this Secondary employment paid or unpaid | | | | | | PAID / UNPAID | | | | | |
| Total hours worked | | | | | | Hours | | | | | |
| **Accident at work** | | | | | | | | | | | | |
| Was the sickness the result of an injury/accident at work? | | YES / NO | | | If YES: have you complied with the necessary procedures (e.g. completed an accident form) | | | | | | | YES / NO |
| **Phased return** | | | | | | | | | | | | |
| Has a Phased Return to Work been agreed? (please note: there must be medical opinion to support a phased return to work, and it should not extend beyond 6 weeks) | | | | | | | | | | | | YES / NO |
| **Declaration** | | | | | | | | | | | | |
| By signing below, I declare that the details given above are true and a ‘Return to Work’ meeting has taken place. | | | | | | | | | | | | |
| **\***Signature of member of staff | | |  | | | | | | Date: | | | |
| **\***Signature of manager/supervisor | | |  | | | | | | Date: | | | |
| **\***Name of manager/supervisor | | | Please print | | | | | | | | | |

# \* = essential