Self Certification Form

TO BE COMPLETED BY THE EMPLOYEE (in Block Capitals)

Name

Department

Period of incapacity

From	To

(Non-working days should be included)

Nature of incapacity

(State any illness, symptoms or describe injury)

Have you noticed any recurrence of any symptoms?

Have you seen a nurse or doctor about it?

(If yes, state doctor or hospital, name and address and treatment or prescription received)

For periods of absence lasting more than 7 consecutive days please confirm that you have provided medical certificates covering the whole of your absence?

Please describe any requirements for further attendance at doctor, hospital or treatment centre in connection with this incapacity? (State doctor or hospital, name and address and treatment or prescription received)

Is there any aspect of your work or any of your duties which you believe will be affected by your recent incapacity?

Signed

Date

On your return to work, please hand this form to your Line Manager or the Chief Executive who will then discuss it with you.

TO BE COMPLETED BY THE LINE MANAGER

I am satisfied/I am not satisfied that the information above is correct.

Signed

Date

Position