CERTIFICATION FORM

This form should be completed on your return to work following any period of absence of 7 calendar days or less and handed to your immediate Supervisor.

If you are returning to work after a sickness absence of more than 7 days you should provide us with a Medical Certificate.

NAME:

DURATION OF ABSENCE:

FROM ……..AM/PM……..TO……AM/PM

DAY ……. ……..DAY
DATE ……. ……..DATE

NOTE: If you were absent by reason of sickness, include non working days.

REASON FOR ABSENCE

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……

…….

Did you consult a Medical Practitioner? YES/NO. If YES please give details of:
Doctors Name, Address, Date of Visit, Treatment Received and any Current Treatment.

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…….

Declaration

I certify that I have been incapable of work for the reason and on the date(s) shown and that this information is true and accurate.

I acknowledge that false information will result in disciplinary action.

I hereby give my employer permission to verify the above information.

Signed …… Date ……

Countersigned ……. (Immediate Supervisor)