****

**CONFIDENTIAL**

Self-certification is required for all absences up to and including 7 days, after which a doctor’s certificate (‘fit note’) will be required.

**Your** **name** ……………………………………………...........………..…………………………………………………………………….….

**I** **was** **absent** **from** **work** **due** **to** **sickness** **or** **injury** **from/to:**

**Absence** **start** **date** ………………………………...…………… **Absence** **end** **date** ……………………..………………………

**I** **was** **unfit** **for** **work** **for** **the** **following** **reason:**

………………………………………...........………..…………………………………………………………………………………………..…..

………………………………………...........………..…………………………………………………………………………………………..…..

………………………………………...........………..…………………………………………………………………………………………..…..

………………………………………...........………..…………………………………………………………………………………………..…..

**Did** **you** **see** **a** **doctor** **or** **visit** **a** **hospital?** **Yes** **/** **No**

**What** **treatment** **did** **the** **doctor** **or** **hospital** **give** **you?**

………………………………………...........………..…………………………………………………………………………………………..…..

………………………………………...........………..…………………………………………………………………………………………..…..

**Does** **this** **treatment** **have** **any** **effect** **on** **your** **ability** **to** **carry** **out** **your** **usual** **tasks** **and** **duties?**

………………………………………...........………..…………………………………………………………………………………………..…..

**DECLARATION:**

I certify that I have been unable to work because of my sickness/injury on the dates shown and that the information I have provided is true and accurate.

**Signature** …................….................................................................................................................…………

**Date** ………….……………………………………………………………….….……………………….……….....................................