



## F2 Sickness Self Certification

**IMPORTANT**

Before you fill in this form it is essential that you read and understand the notes below. If you have any problems, contact the Administration Department before giving the information requested. Do not forget to sign the form.

**PLEASE COMPLETE IN BLOCK CAPITALS – ANSWER ALL QUESTIONS**

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1. Workplace (Project/Department).....
2. Full Name: Mr/Mrs/Miss/Ms/Dr.....
3. Nature of illness/injury:.....
4. If your absence is due to accident/disease please indicate by circling the relevant section:  
 (a) Injury at Work) (b) Industrial Disease (c) Accident involving 3<sup>rd</sup> party (d) Other cause
5. Please indicate below with a ✓ days actually sick and non working days within the sick period.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Date:	Date:	Date:	Date:	Date:	Date:	Date:
AM	AM	AM	AM	AM	AM	AM
PM	PM	PM	PM	PM	PM	PM
NIGHT	NIGHT	NIGHT	NIGHT	NIGHT	NIGHT	NIGHT

**Please note that if your illness lasts for more than 7 days, including Saturdays, Sundays & Bank Holidays, you must obtain a Medical Certificate from your GP or Hospital.**

6. My first Day of Sickness absence was:  
 Day...../Month...../Year.....
7. I was fit on:.....and resumed/will resume work on:.....
8. Total days absent (including non-working days):.....

**PTO ←**

**DECLARATION**

I have read the notes below and I declare that to the best of my knowledge the information given in this form is correct I hereby claim the entitlements due to me under the Occupational Sickness Pay Scheme operated by ELHAP together with the allowances provided under the Social Security Contributions and Benefits Act 1992. I acknowledge that disciplinary action may be taken against me if I knowingly make a false statement.

Name.....

Signed.....

Dated.....

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**NOTES ON FILLING IN THE FORM**

Question 3 If possible try to give a specific description of the illness/injury (e.g. Influenza etc.)

Question 6 state the date when you became ill or were injured, whether or not you were at work at the time (illness which occurs during non-working days will counts for Statutory Sick Pay purposes)

YOU ARE OBLIGED TO FOLLOW THE AGREED PROCEDURES, OTHERWISE ENTITLEMENTS TO OCCUPATIONAL AND/OR STATUTORY SICK PAY MAY BE AFFECTED

**FOR MANAGERS COUNTER SIGNATURE/AUTHORISATION**

Authorised for payment **YES / NO\*** Reasons for non-authorisation:

.....

Name:..... Signed:.....

Dated:.....

To be copied on pink paper

**F3**  
**Back To Work Interview Pro-forma**

Staff name: \_\_\_\_\_ Supervisor name: \_\_\_\_\_

Date of absence: \_\_\_/\_\_\_/\_\_\_ Date of return: \_\_\_/\_\_\_/\_\_\_ Date of interview: \_\_\_/\_\_\_/\_\_\_

Please note that individual absence records can be requested from the Administration Department

**Welcome**

**Absence** (talk about reasons for absence, explore possibility of underlying problems and any past absences)  
**WHAT ACTION DID THE EMPLOYEE TAKE TO EFFECT RECOVERY** (eg treatment received)

**IS THE EMPLOYEES RECEIVING ANY ON-GOING TREATMENT, AND IF SO, WHAT?**

**IS THE EMPLOYEE FIT TO CARRY OUT HIS/HER DUTIES** (if not, what are the limitations, (eg bending, driving etc.)

**DOES THE EMPLOYEE ENVISAGE FURTHER TIME OFF WORK DUE TO THIS OR RELATED HEALTH PROBLEMS** (e.g. follow up appointments)

**COMMENTS/RECOMMENDATIONS** (eg referral to the Medical Office, temporary alternative duties etc)

**ADDITIONAL COMMENTS IF APPROPRIATE (LINE MANAGER OR EMPLOYEE)**

**Note agreed action on page 2**

**Responsibility** (talk about responsibility of individual to attend work regular, what they are doing to ensure that they can i.e. Doctors, counselling, medication, exercise, stopping smoking, losing weight etc.)

**Note agreed action on page 2**

**Move on** (talk about what has been going on at work, and what needs to be done)

**F3**  
**Back To Work Interview Pro-forma**  
 Continued...../2.

Staff name: \_\_\_\_\_ Supervisor name: \_\_\_\_\_

Number of absences in last 12 months: \_\_\_\_\_ Number of occasions: \_\_\_\_\_  
 (Manager to obtain an absence report from Administration Department)

**Action (e.g. \*Welfare Review/first day medical certificate/Referral to Occupational Health/Reasonable Accommodation/other):**

\*delete as appropriate

**Review Date:**

Review Date	Review Carried out/Further Action	Reasons review not carried out
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Signed staff member: ..... Print: ..... Date: \_\_/\_\_/\_\_

Signed Supervisor: ..... Print: ..... Date: \_\_/\_\_/\_\_

Signed Manager: ..... Print: ..... Date: \_\_/\_\_/\_\_

This note to be retained on the supervision file.











**F6**  
**Occupational Health Sickness Referral Request Form**

Employee: .....

Post: .....

Project: .....

Please provide details of employee's sickness absence, including nature of illness/injury and number of occurrences of absence:

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Please indicate questions you want specific answers to from Occupational Health Department

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If the employee is found to be temporarily or permanently unfit, would alternative work or initially reduced hours be available?

Yes

No

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Signed: \_\_\_\_\_ Dated: \_\_\_\_\_

# F7 Consent to Obtain a Medical Report

**Please read carefully the following notes and the declaration in Part B before completing this form.**

Before we can apply for a medical report from your Consultant/Doctor, we need your consent. Before signing this consent from you should know that you have certain rights under the Access to medical Reports Act 1998. In summary, these are as follows:

- (i) You can withhold your consent;
- (ii) You can see the report before it is sent to us, or during the six months after that;
- (iii) You can ask your Consultant/Doctor if he/she will amend any part of the report, which you consider to be incorrect or misleading. If the Consultant/Doctor is not in agreement, you may add your comments to his/her report;
- (iv) Your Consultant/Doctor can withhold all or part of the report from you if it could cause you serious physical or mental harm, or would include revealing information about another person;
- (v) If you have decided you would like to see the report first you will have 21 days in which to make arrangements with the Consultant/Doctor to see the report. You must make these arrangements yourself.

**PART A** (Your name and address)

**SURNAME:**.....

**FORENAME(S):**.....**(Mr/Mrs/Miss/Ms)**

**HOME ADDRESS:**.....

.....**Telephone No:**.....

**PART B**

I have been informed of my statutory rights under the Access to medical Reports Act 1998, and I hereby consent to the Occupational Health Medical Adviser seeking medical information about me from:

**G.P.:**..... **Consultant:**.....

**Address:**..... **Address:**.....

.....**Telephone No (if known):**..... **Telephone No(if known):**.....

**PART C**

( ) I wish to see the report before it is sent to the Occupational Health Department.

( ) I do NOT wish to see the report before it is sent to the Occupational Health Department.

**Signed:**..... **Dated:**.....

## **Access To Medical Reports Act 1998 Explanatory Note**

This note outlines the application of your rights under the provisions of the Access to Medical Reports Act 1988 and explained the procedure for applying these rights. Under the Act an employer should not apply for a medical report from a doctor who has been responsible for your physical or mental health care without your consent. The consent form asks, in accordance with the Act, whether you wish to see the report before it is sent to the Occupational Health Department.

If you decide that you would like to see the report first, the Occupational Health Department will inform the doctor of that fact and will notify you of the date that the application for the medical report is actually made. You will then have 21 days in which to make arrangements with your doctor to see the report. You must make these arrangements yourself; the Occupational Health Department cannot make them for you. Whilst there is no charge for reading the report, if you arrange with your doctor to have the report photocopied and if necessary, posted to you, the doctor may charge a reasonable fee to cover costs.

If you did not indicate on the consent form that you wished to see the report, but later change your mind, you may still, on your own behalf, notify your doctor that you wish to see the report before it is sent to the Occupational Health Department. You will then have 21 days from the date of your notification to the doctor to make an arrangement to see the report. Please note however, that the doctor is not obliged to delay supplying the report to the Occupational Health Department in case you change your mind. By the time you have decided that you would rather see the report first, the doctor may already have supplied it to the Occupational Health Department.

If, following notification to the doctor, you have seen the report; the doctor is not empowered to supply the report to the Occupational Health Department without your further consent. Having seen the report you will be entitled to request that the doctor amend any part which you consider to be inaccurate or misleading. If the doctor does not agree to the amendment as requested, but you will wish the report to be sent, you have the right to attach a written statement giving your view on its content.

Whether or not you decide to see the report before it is supplied to the Occupational Health Department, the doctor will be obliged to keep a copy for at least six months after the date it was supplied to the Occupational Health Department and you will be entitled to have access to that report.

Please note that the doctor is not obliged to let you see those parts of the medical report that he or she believes would be likely to cause serious harm to your physical or mental health or that of others, or which would reveal information about another person or the identity of a person who has supplied the doctor with information about your health unless that person also consents. In those circumstances your doctor will notify you and you will be limited to seeing any remaining parts of the report.

**PLEASE KEEP THIS EXPLANATORY NOTE FOR FUTURE REFERENCE.**

Revised November 2002

## F8 Entitlement to Occupational Sick Pay Table

Continuous Service		Entitlement
From	Up to	
0	1 year	5 days full pay, 2 days ½ pay
1 year	3 years	10 days full pay, 3 days ½ pay
3+years	Onwards	20 days full pay, 3 days ½ pay

Length of Service: Under 1 year	
Length of Sickness Absence	Entitlement
<b>1 – 3 sick days</b>	<b>Full pay*</b>
<b>4+ sick days</b>	<b>Statutory sick pay</b>
*Employees are entitled to a total of <b>5</b> days of Standard Occupational Sick Pay for the first 3 days of a sick leave period in one year. Once the <b>5</b> day entitlement has been used, the employee will receive Extended Occupational Sick Pay for a further <b>2</b> days of a sick leave period (except when the employee has taken a second sick leave period within 8 weeks)	

Length of Service: 1 year – 3 years	
Length of Sickness Absence	Entitlement
<b>1 – 3 sick days</b>	<b>Full pay*</b>
<b>4+ sick days</b>	<b>Statutory sick pay</b>
*Employees are entitled to a total of <b>10</b> days of Standard Occupational Sick Pay for the first 3 days of a sick leave period in one year. Once the <b>10</b> day entitlement has been used, the employee will receive Extended Occupational Sick Pay for a further <b>3</b> days of a sick leave period (except when the employee has taken a second sick leave period within 8 weeks)	

Length of Service: 3 years onwards	
Length of Sickness Absence	Entitlement
<b>1 – 3 sick days</b>	<b>Full pay*</b>
<b>4+ sick days</b>	<b>Statutory sick pay</b>
*Employees are entitled to a total of <b>20</b> days of Standard Occupational Sick Pay for the first 3 days of a sick leave period in one year. Once the <b>20</b> day entitlement has been used, the employee will receive Extended Occupational Sick Pay for a further <b>3</b> days of a sick leave period (except when the employee has taken a second sick leave period within 8 weeks)	

**F9**  
**Welfare Review Interview Pro-forma**

Staff name: \_\_\_\_\_ Supervisor name: \_\_\_\_\_

HR Advisor: \_\_\_\_\_

Date of absence: \_\_\_/\_\_\_/\_\_\_ Date of return: \_\_\_/\_\_\_/\_\_\_ Date of interview: \_\_\_/\_\_\_/\_\_\_

Please ensure that an absence record is supplied/attached for this welfare review meeting.

**Welcome**

**Absence** (talk about reasons for absence, explore possibility of underlying problems and any past absences)

**Note Agreed Action on Page 2**

**Responsibility** (talk about responsibility of individual to attend work regular, what they are doing to ensure that can i.e. Doctors, counselling, medication etc.)

**Note Agreed Action on Page 2**

**Move on** (talk about what has been going on at work, and what needs to be done)

**HR10 F9**  
**Welfare Review Interview Pro-forma**  
 Continued.....2/.

Staff name: \_\_\_\_\_ Supervisor name: \_\_\_\_\_

HR Advisor: \_\_\_\_\_

Number of absences in last 12 months: \_\_\_\_\_ Number of occasions: \_\_\_\_\_

**Action (e.g. \*Welfare Review/first day medical certificate/Referral to Occupational Health/Reasonable Accommodation/other):**

\*delete as appropriate

**Review Date:**

Review Date	Review Carried out/Further Action	Reasons review not carried out
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Signed staff member: ..... Print: ..... Date: \_\_/\_\_/\_\_

Signed Supervisor: ..... Print: ..... Date: \_\_/\_\_/\_\_

Signed Manager: ..... Print: ..... Date: \_\_/\_\_/\_\_

This note to be retained on the staff supervision file and a copy to be held on the Personal File.