|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **PART 1 of this form must be completed in BLOCK CAPITALS on the first day of absence from work:** | | | | | | | | | | | | | | | | | | |
| **Name** | |  | | | | | | **Place of Work** | | | | |  | | | | | |
| Job Title | |  | | | | | | **Contract No.** | | | | |  | | | | | |
| **Working Pattern** (please enter no. of contractual hours on each day normally worked)  **\*\*\*Please ensure this section is fully completed\*\*\*** | | | | | | | | | | | | | | | | | | |
| |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | MON | TUES | WED | THUR | FRI | SAT | SUN | TOTAL | |  |  |  |  |  |  |  |  | | | | | | | | | | | | | | | | | | | |
| Notification of sickness | | | | Time | |  | | | | | | | Date | | |  | | |
| First day of sickness | | | | Time | |  | | | | | | | Date | | |  | | |
| Last Day of Absence | | | | Time | |  | | | | | | | Date | | |  | | |
|  | | | | | | | | | | | | | | | | | | |
| Detail the nature\* of the sickness causing absence from work? [Terms such as “sick” or “unwell” are unacceptable] | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **Number of periods of sickness absence** | | | | | Previous 6 months | | | | | | |  | | | Previous 12 months | | |  |
| Is the absence due to work-related event?  (*e.g. accident at work or work-related ill-health*) | | | | | Yes | | | | | |  | | | | No | | |  |
| An Incident Report Form must be completed where the absence is work-related and a copy sent to the Health and Safety team. | | | | | Incident Report form reference Number | | | | | | | | |  | | | | |
| **If the absence is work-related and for more than 3 days please inform the CST HR Manager immediately** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **PART 2 of this form must be completed by the employee on return to work in the presence of their Line Manager/ Office Manager or a member of the SLT.** | | | | | | | | | | | | | | | | | | |
| Number of Days Absent From Work | | |  | | | | | | Date returned to work: | | | | | | | |  | |
| **Any information in addition to that in Part 1** | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | |
| **I declare** that the information, contained in Parts 1 and 2 above, is to the best of my belief, true and complete and that I understand if I provide inaccurate or false information I may be liable to disciplinary action which could include dismissal. | | | | | | | | | | | | | | | | | | |
| **Employee signature:** |  | | | | | | **Date:** | | |  | | | | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| A. Fit for Work: | | | | | | | | | | | | | | | | | | | | | |
| Employee comments relating to the absence: | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **Comments of supervisor or manager, including action taken and recommendations for the future (taking into account any breaches of trigger points):** | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **B. May be Fit for Work: with the following advice** (please tick and enter information from ‘statement of fitness for work’ | | | | | | | | | | | | | | | | | | | | | |
| Phased Return | | |  | | Altered Hours | |  | Amended duties | | | | |  | | Workplace Adaptions | | | | | |  |
| **Period of Adjustment** | | | **From:** | | | |  | | | | **To:** | | | | | |  | | | | |
| GP’s Comments: | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **C. Can the Fit Note advice be Implemented?** | | | | | | Yes | |  | | | | No | | | | | | |  | | |
| If Yes Please outline arrangements implemented (carry out risk assessment if necessary). If No please specify reasons why the fit note advice cannot be implemented. If unsure seek further advice and then complete this section. | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| **D. Action Taken** (information to be transferred onto absence return where appropriate) | | | | | | | | | | | | | | | | | | | | | |
| Phased return to work |  | | | Amended duties | | | | |  | Altered hours | | | | | |  | | | | Home Visit |  |
| Workplace adaptations |  | | | OH Referral | | | | |  | Attendance Consultation Meeting | | | | | |  | | | | Informal warning |  |
| Formal warning |  | | | Fit Note Risk Assessment | | | | |  | Other | | | | | |  | | | | No Action |  |
| Details: | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | |
| E. Declaration I also declare that the information in Part 3 is a correct record of the discussions at the return to work interview. | | | | | | | | | | | | | | | | | | | | | |
| **Employee Signature** | |  | | | | | | | | | | | | **Date** | | | |  | | | |
| **Supervisor/Manager Signature:** | |  | | | | | | | | | | | | **Date** | | | |  | | | |

This form and its contents are highly confidential and must be returned to the office manager for entering on the A1 Form and filing on the employee’s personal file. Employees must be given a photocopy of the completed form if one is requested