***Version 1.1 - last updated on 10 October 2022***

***Please contact the Bright Advice team on 0481 609 489 for any specific questions on content or if you are intending to make amendments to the contents of this document.***

*This document and any associated advice are not intended to be comprehensive. The document and associated services are designed for you to be able to inform yourself generally, on common employment relations concepts and issues.*

*The document has not been created in line with your specific needs, objectives or circumstances in mind and is not formal advice. Before you act or rely on our service, you should seek formal advice from an appropriately qualified practitioner. While we use reasonable effort to ensure the accuracy of documents, we do not represent, warrant, or guarantee its accuracy, currency or completeness (to the maximum extent permitted by law).*

*This document must be transferred to your own letterhead, removing this disclaimer.*

sickness certification form

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| *This form should be completed on your return to work following any period of sickness.* |
| First Name: |
| Last Name: |
| Department [DELETE IF NOT APPLICABLE]: |
| **Dates of sickness***(Including non-working days)* |
| **From** | **To** |
| Time: (am/pm) | Time: (am/pm) |
| Day: | Day: |
| Date: / / | Date: / / |
| **Dates of absence from work***(including non-working days)* |
| **From** | **To** |
| Time: (am/pm) | Time: (am/pm) |
| Day: | Day: |
| Date: / / | Date: / / |
| **Details of sickness or injury** |
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|  |
|  |
| **Did you consult a Doctor?** | ○YES | ○NO |
| If YES, please give details of: Doctor’s name, address, date of visit, treatment received and any current treatment. If NO, please state why not.  |
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| Declaration |
| I certify that I was incapable of work because of my sickness/injury on the date(s) shown above and that this information is true and accurate.I acknowledge that false information may result in disciplinary action.I hereby give my employer permission to verify the above information. |
| Signed: | Acknowledged: |
| *(employee)* | *(for employer)* |
| Date: / / |  |