



**SICK LEAVE FORM**

**PART A – (To be completed by Employee.)**

Full Name: ..... Site:.....

Date Submitted: ...../...../..... Number of Days Sick Taken : .....

Leave Period From: ..... Hrs On: ...../...../.....

To : ..... Hrs On: ...../...../.....

Date of Return to Duty: ...../...../.....

Doctor’s certificate provided? YES/ NO.\* (Please attach to this form).

Please provide a brief description of your illness in the space provided below.....

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Signed: .....

Date.....

**\*PLEASE NOTE CERTIFICATION MUST BE PROVIDED FOR PERIODS OF SICKNESS GREATER THAN SEVEN DAYS.**

**PART B - For Office use**

No. OF DAYS TAKEN SINCE START ANNUAL START DATE: .....

No. OF DAYS SICK ON FULL PAY SINCE ANNUAL START DATE: .....

No. OF DAYS TO BE PAID AT FULL PAY: .....

No. OF DAYS TO BE PAID AT SSP: .....

DOCTORS CERTIFICATION PROVIDED: YES/ NO

REMARKS:.....

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APPROVED BY: \_\_\_\_\_ DATE : \_\_\_\_\_