

|  |
| --- |
| Sickness Notification / Self-Certification Form |
| Payroll Section  Finance  McCance Building  16 Richmond Street  Glasgow  G1 1XQ  Tel: 0141 548 4454  Fax: 0141 552 2462  Email: [monthly.absence.returns@strath.ac.uk](mailto:monthly.absence.returns@strath.ac.uk) |
| Contents  [ Part A - To be completed when informed of sickness absence. 1](#_Toc345590094)  [ Part B - Fourth working day of absence notification. 1](#_Toc345590095)  [ Part C - Confirmation of absence details. 1](#_Toc345590096)  [ Declaration 1](#_Toc345590097) |

|  |
| --- |
| **Parts A and B** to be completed by the person taking the calls regarding absence from work due to sickness.  **Part C** to be completed by the Head of Department (or designated nominee) and the member of staff on his/her return to work. Once completed forward to the Payroll section. |

# Part A - To be completed when informed of sickness absence.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  | | | |
| Department: |  | | | |
| First Date of Sickness: |  | | | |
| Nature of Sickness: |  | | | |
| Is the absence the result of an injury at work? |  | Expected Length of Absence:  (If known) |  | |
| If yes, complete the [Safety Incident Webform](https://eur02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fsafe360.info-exchange.com%2Fsafetyincidents&data=05%7C01%7Coperationalsupporthr%40strath.ac.uk%7Cbec8153d79be405114e708da275a1742%7C631e0763153347eba5cd0457bee5944e%7C0%7C0%7C637865565125643829%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=skFRoIJdHCLe1YZqqjdDSwYJZJWQXmgFPzfvDxB%2By%2Bg%3D&reserved=0) or contact [safety@strath.ac.uk](mailto:safety@strath.ac.uk). | | | | |
| Notes: (e.g. if contact was made by family member) |  | | | |
| Message Taken By: (name) |  | Date Completed: | |  |

# Part B - Fourth working day of absence notification.

|  |  |  |  |
| --- | --- | --- | --- |
| Notes:  (e.g. expected length of absence changed / contact made by family member) |  | | |
| Message Taken By: (name) |  | Date Completed: |  |

# Part C - Confirmation of absence details.

|  |  |  |  |
| --- | --- | --- | --- |
| Last Date of Sickness: |  | | |
| No. of Working Days Absent: |  | | |
| Signature: (Head of Department or designated nominee) |  | Date Signed: |  |

# Declaration

|  |  |  |  |
| --- | --- | --- | --- |
| I certify that between the dates noted at Parts A and C, I have been unable to work due to personal illness. The nature of my illness was as stated above, or if different as follows: | | | |
| If different: |  | | |
| Signature: (Staff Member) |  | Date: |  |