airglide
Umbrella Services

ABSENCE / SICKNESS FORM

Full Name : _____

Department |: _____

First Day of Absence : _____Last day of absence : _____

Date of return to work : _____ Total days of absence : _____

Reason for absence : _____

_____

When did you notify the Company of your sickness? _____

Whom did you notify ? _____

Did you obtain a medical certificate ? _____
(Please attach where applicable)

For Health and Safety purposes to ensure the safety of yourself and of others :

Are you taking any medication? _____
(Please give details)

_____

DECLARATION

I declare that all information I have given in this form is true and that I have not withheld any facts.

I understand these details will be held in confidence by the Company and may be used for the following purposes in compliance with the Data Protection Act 1998:

- Ensuring the Health, Safety and Welfare at work of myself and other workers
- The avoidance of discrimination on the grounds of disability
- Maintaining SSP and SMP records
- Ensuring the Company is able to monitor and fairly with attendance and absence issues

Signature of Employee : _____Date : _____

Signature of Manager : _____Date: _____

Fax No : 0800 500 3196 or Email : info@airglideus.com