**Return to Work Form**

|  |  |
| --- | --- |
| Name of Employee |  |
| Last Absence |
| Date of first day of sickness: |  |
| Date of last day of sickness: |  |
| Total number of working days lost due to sickness: |  |
| Reason for Absence: |  |
| Total Sickness Absence record over the last 12 calendar months |
| Total number of Occasions: |  |
| Total number of working days off: |  |
| Total number of medically certified working days off: |  |
| Reason for occasions: |  |
| Question | Yes | No |
| Does the Employee feel fit enough to return to work?If no, please explain further: |  |  |
| If this is a recurring illness or likely to occur again?If yes please give details: |  |  |
| Did the Employee seek any medical advice?If yes, please give details: |  |  |
| Is the Employee taking any medication that may affect their work?Eg drowsiness/dizziness. If yes, please give details: |  |  |
| Was the absence caused or made worse by workplace factors?If yes, please give details: |  |  |
| Have the relevant forms been handed in? Eg Medical Certificates. |  |  |
| If absence was due to an injury sustained at work has form HS1 Accident Report, or HS3 Incident of Violence Report been completed and the Health & Safety Officer informed? |  |  |
| If the Absence was caused by a third party accident, has the appropriate form been filled in to notify payroll ( who will seek a claim against the insurer )? |  |  |
| Is any action required to facilitate the employees return to work? If yes please give details: |  |  |
| Action Required/Agreed | Yes  | No |
| Is the amount/Level of sick absence causing concern? |  |  |
| Is a referral to the Occupational Health Specialist appropriate? |  |  |
| Is a risk assessment required? (Including stress risk assessment ) |  |  |
| Risk Assessment Tool: |
| Description of Riske.g the employee is required to lift heavy items but this may make health worse. | Impact –Medical situation could have on carrying out duties | Probability –Medical situation could have on carrying out duties | Actioni.e reasonable adjustments, training, equipment or support  |
|  | High,Medium orLow | High, Medium orLow |  |
|  |
| Further action Required?Eg, Counselling, Oh referral. |  |
| Any other Comments: |  |
|  |
| Signature of Employee: |  |
| Date: |  |
| Signature of Manager:  |  |
| Date: |  |