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| **UNIVERSITY COLLEGE DUBLIN**  **Self-Certified Sick Leave Form** |

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| ***This form is to be completed immediately on return to work in respect of each day(s) of self-certified sickness/absence and given to your Head of School/Unit, Line Manager or their nominee.***  ***Where an employee exceeds the 7 days self-certified leave in a rolling 24-month period, s/he is required to provide a medical certificate for all future absences. Failure to do so is considered a breach of university regulations and may lead to disciplinary action. If a medical certificate is not provided, the day(s) of sickness absence will be unpaid.*** |

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| Name: | Personnel No: P |
| School/Unit: | Line Manager: |
| If part-time or job sharing, please state pattern of working week:   * ***Please note entitlements for part-time, job sharing and probation entitlements are pro-rata*** | |
| Date my self-certified sick leave commenced: | Date my self-certified sick leave ended: |
| Date I returned to work: | Number of days of this self-certified absence: |
| Nature of illness: | |
| I understand that I must submit a medical certificate from the 3rd day of a continuous period of sick leave: | |

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| **DECLARATION**  *I confirm that I have taken self-certified sick leave on the above-mentioned date(s) as I was unfit for work due to illness/injury. I declare that the information given above is true and complete.* | | | |
| **Signature of Employee:** |  | **Date:** |  |

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| **To be completed by Head of School / Unit or Manager:**  Total number of days of self-certified sick leave taken in the count back period preceding the absence(s):  Number of days to be recorded as self-certified sick leave or unpaid absence | | | |
| **Signature of Head of School/Unit, Line Manager:** |  | **Date:** |  |

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| **To be completed by School/Unit Sick Leave Administrator and emailed to**  **HR Operations, UCD Human Resources at** [**sickleave@ucd.ie**](mailto:sickleave@ucd.ie%20)  Sick leave recorded on CoreHR/PXD as self-certified sick leave or Advised HR of unpaid absence | | | |
| **Signature of Sick Leave Administrator:** |  | **Date:** |  |