

Sick Leave Form

Employee Information

- Employee Name: _____
- Department: _____
- Employee ID: _____

Medical Details

- Doctor's Name (if applicable): _____
- Medical Facility: _____
- Illness/Injury Description:

Leave Duration

- Start Date of Leave: _____
- Expected Return Date: _____

Certification

- Medical Certification Attached:

- () Yes
- () No

- Employee Signature: _____ Date:

- Supervisor's Signature: _____ Date:
