Name…………………………..............................................................................................................

Job Title………………………………………………………Employee No.......................................

First date of absence……………...................Return-to-work date………………………………...

Reason for absence………………………….......................................................................................

* If reason for absence could have an impact upon food safety (including gastrointestinal illness / infectious disease), complete **questionnaire** below.
* Where no food safety implications are present, proceed directly to **declaration**.
* If you have been absent due to ill health for more than 7 days, you will be required to obtain a **medical certificate** from your doctor.

**Questionnaire**

|  |  |
| --- | --- |
| **KEY SYMPTOMS** | * *Stomach pain*
* *Vomiting or diarrhea*
* *Skin complaints*
* *Discharge from the eyes /ears /mouth including heavy cold /cough*
 |
| **No.** | **Question** | **Yes** | **No** |
| **1** | Are you **currently** suffering from any of the symptoms listed above? |  |  |
| **2** | Have you suffered from any of the symptoms listed above during your **period of absence** from work? |  |  |
| **3** | Have you suffered from any of the symptoms listed above in the **last 48 hours**? |  |  |
| **4** | Have you taken medication for symptoms listed above during your period of absence from work? |  |  |
| **5** | Have you visited a doctor or hospital during your absence from work? |  |  |
| **6** | Have you travelled outside of Europe in the past 3 months? |  |  |
| **7** | Have you suffered from or been in contact with people suffering from the following conditions in the past 21 days?* Hepatitis or Jaundice
* Food poisoning (including salmonella or e-coli)
* Typhoid or Paratyphoid
 |  |  |

**Declaration**

**WORKER TO COMPLETE**

***All information provided on this form is accurate to the best of my knowledge***

Signature…………...……………………….…………………………………………………………..

Worker name (print)…………………………..……………………………………………………….

Date……………………………………………………………………………………………………...

|  |  |  |
| --- | --- | --- |
|  | Yes  | No |
| Approved to return to work? |  |  |
| Approved to resume food handling role (where applicable? |  |  |
| Comments: |

**SUPERVISOR OR MANAGER TO COMPLETE**

Signature…………...……………………….………………………………………………………….

Name of supervisor or manager (print)...……………………………………..…………………….

Date……………………………………………………………………………………………………..