# FOOD HANDLER'S RETURN TO WORK FOLLOWING SICKNESS FORM

*This form is to be completed by the employee before returning to work, then checked by a manager or supervisor to ensure the employee is fit to return to their duties.*

| **Personnel details** | | |
|---|---|---|
| **Full name:** | | |
| **Telephone number:** | | |
| **Which manager/ supervisor was informed on the first day of absence?** | | |
| **Dates absent:** | **From:** | **To:** |
| **Total number of days absent:** | | |

| **Symptoms** | | |
|---|---|---|
| **Did you suffer from any of the following?** | | |
| **Diarrhoea** | **Yes** □ | **No** □ |
| **Vomiting** | **Yes** □ | **No** □ |
| **Nausea** | **Yes** □ | **No** □ |
| **If you answered yes to any of the above, have you been clear of symptoms for at least 48 hours?** | **Yes** □ | **No** □ |
| **Skin condition** | **Yes** □ | **No** □ |
| **If you answered yes, has this now fully healed?** | **Yes** □ | **No** □ |
| **Discharge from the Eyes, Ears or Nose** | **Yes** □ | **No** □ |
| **If you answered yes, have the symptoms now stopped?** | **Yes** □ | **No** □ |
| **Did you visit a doctor?** | **Yes** □ | **No** □ |
| *If yes, give details below of any treatment, including any ongoing medications* | | |

| **I confirm that I have completed this document to the best of my knowledge, giving accurate and correct information.** | | |
|---|---|---|
| **Employee signature:** | | |
| **Date and time of completion:** | **Date:** | **Time:** |
| **Name of manager/supervisor checking document:** | | |
| **Signature:** | | |
| **Position:** | | |
| **Date and time of completion:** | **Date:** | **Time:** |

** For any additional information continue overleaf as necessary.*

*This completed form should be retained in the employee's folder*