**Sick Leave Request and Medical Certificate Form**

**Section A – Employee Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Employee Name | Sarah Ahmed | **Employee ID:** | EMP-4587 |
| Position | Content Specialist | Department | Marketing |
| **Contact Number** |  | **Email Address** |  |

**Section B – Sick Leave Details**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Request | 21-Oct-2025 | First Day of Absence | 20-Oct-2025 |
| Expected Return Date | 23-Oct-2025 | Total Days Requested | 4 |
| Reason for Leave | Flu | Has this leave been discussed with your supervisor? | ☐ Yes ☐ No |

**Section C – Employee Declaration**

I hereby declare that the information provided above is accurate. I understand that I may be required to provide medical documentation to support my absence.

**Employee Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D**ate:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section D – Medical Certificate (To Be Completed by Licensed Medical Practitioner)**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Name |  | Date of Examination |  |
| Nature of Illness / Condition |  | Recommended Rest Period (From – To) |  |
| Fit to Resume Duty on |  | Additional Remarks / Restrictions |  |
| Physician’s Name | Dr. Ali Hassan | Medical License No. |  |
| Clinic / Hospital Name | City Health Clinic | Contact Number |  |
| **Signature and Official Stamp** | |  | |

**Section E – Office Use Only**

|  |  |  |  |
| --- | --- | --- | --- |
| Supervisor’s Review | ☐ Approved ☐ Denied | Comments |  |
| HR Department Review | ☐ Recorded ☐ Pending | HR Officer’s Name |  |
| Signature |  | Date: |  |