

# PATIENT REQUEST FOR SICKNOTE

**[DO NOT USE THIS FORM TO REQUEST MEDICATIONS OR FOR ADVICE]**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

First Line of Address and Postcode: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

## Statement of Patient

- **Do you need to speak to the Doctor regarding the sick-note prior to processing this request?**  
Yes  No

- **I request :**

New sick-note:

Continuation sick-note:

- **Due to the following reason:** \_\_\_\_\_

- **Can your sick-note state that you may be able to work if...?** e.g. You could work altered hours or reduced/restricted duties? Yes  No

If yes please give details: \_\_\_\_\_

- **Duration of sick-note:**

1 week  2 weeks  3 weeks  4 weeks

Other duration:  \_\_\_\_\_

- **Sick note is due on:** (Date): \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

- **Please note if the sick-note request is not correctly filled, there will be a delay or non-processing of your request.**
- **Please allow a minimum of 48hours to process your sick-note.**
- **Please note some sick-note requests may result in rejection or the need for a telephone or face-to-face review prior to issue of your sick-note.**