AMP GROUP PRACTICE

**PATIENT SICK / FIT NOTE REQUEST FORM**

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| **IMPORTANT INFORMATION - PLEASE READ CAREFULLY** |
| * **Please note that this form must be completed in full, submitting an incomplete form may result in a delay in your sick note request**

**being processed.** |
| * **Sick note requests will only be processed when they are due, under no circumstances are we able to provide a post-dated sick note**
 |
| * **Sick note requests will only be processed if the patient has been seen by a GP, nurse or hospital consultant in the preceding 8 weeks**
 |

PATIENT SIGNATURE:

Date:

 from:

 until:

DATES REQUIRED FOR SICK NOTE:

EMPLOYER'S NAME / DWP DETAILS:

HOME PHONE №:

MOBILE PHONE №:

REASON FOR SICK NOTE REQUEST:

(please give as much detail as possible)

PATIENT NAME: DATE OF BIRTH: ADDRESS:

**TO BE COMPLETED BY THE PATIENT**

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| **OFFICE USE ONLY** |
| **CLINICAL ASSESSMENT OF SICK NOTE EXTENSION REQUEST** |
|  |  |
| Notes checked: (please tick) | YES |  | NO |  |
| Request approved: (please tick) | YES |  | NO |  |
| Notes: |

|  |
| --- |
| **GP AUTHORISATION FOR SICK NOTE EXTENSION TO BE PROCESSED** |
| Reviewed by: | Dr | Signed: |  |
| APPROVED: (please tick) | YES |  | NO |  |
| IF SICK NOTE EXTENSION IS NOT APPROVED PLEASE GIVE FURTHER GUIDANCE BELOW |
| SEE GP |  | SEE NURSE CLINICIAN |  | TELEPHONE CONSULTATION |  |

I understand:

The clinician has a right to refuse my request

Unless I hear otherwise I can collect my note from the reception desk in 3 working days