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**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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