

# AUSTRALIAN SICK LEAVE FORM

Employee Information:

**Full Name:** \_\_\_\_\_

**Employee ID (if applicable):** \_\_\_\_\_

**Department:** \_\_\_\_\_

**Position:** \_\_\_\_\_

Employer Information:

**Company Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Contact Number:** \_\_\_\_\_

Sick Leave Details:

**Date(s) of Absence:** \_\_\_\_\_

**Total Sick Leave Days Taken:** \_\_\_\_\_

**Reason for Leave (brief description):** \_\_\_\_\_

Medical Certification:

I hereby certify that the above-named employee was medically unfit for work during the period(s) stated above. This certification is issued in accordance with applicable Australian workplace laws and guidelines. The employee has complied with the requirements under the Fair Work Act 2009 regarding notice and evidence for sick leave.

**Medical Practitioner Information:**

Full Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Number: \_\_\_\_\_

**Legal Compliance Notice:**

This Sick Leave Form is governed by the Fair Work Act 2009 and related Australian workplace laws. False or misleading statements in this form may constitute a breach of applicable laws and may result in disciplinary action or legal penalties.

**Employee Declaration:**

I declare that the information provided in this form is true and correct to the best of my knowledge. I understand my obligations under the Fair Work Act 2009 and agree to provide additional evidence if requested by my employer.

**EMPLOYEE SIGNATURE**

**MEDICAL PRACTITIONER SIGNATURE**

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

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

Date: \_\_\_\_\_

Date: \_\_\_\_\_

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