# APPENDIX 1



**SCHOOL OF HEALTH SCIENCES**

SELF CERTIFICATION OF ILLNESS FORM

THIS FORM IS TO BE USED TO CERTIFY PERIODS OF ILLNESS FROM 3-5 CONSECUTIVE DAYS. A MEDICAL CERTIFICATE SHOULD BE SUPPLIED FOR PERIODS OF MORE THAN 5 CONSECUTIVE DAYS.

Name (Please Print) ……………………………………………………………………………………………………………………………

Degree Programme ………………………………………….. Year of study………………….

I wish to inform you of my absence on:

Date(s) From: ……………………………………………………………………...

 To: ……………………………………………………………………..

# Number of days in total: ……………………………………………………………

Number of \***practice**days: ……………………………………………………………

Number of \***academic** days: ……………………………………………………………

Reason for absence: ………………………………………………………………………………………………………………..

……………………………………………………….………………………………………………………………………………………………..

Signed: ………………………………………………Date: ……………………………

# \* practice=days absent from clinical placement/professional practice \* academic=days absent from University

**THIS FORM SHOULD BE RETURNED TO THE STUDENT EXPERIENCE PROGRAMME ADMINISTRATOR ON THE FIRST DAY OF YOUR RETURN TO THE UNIVERSITY/PLACEMENT AFTER THE PERIOD OF ILLNESS.**