**NHS Greater Glasgow and Clyde**

**Attendance Management**

**Supporting a Return to work**

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| **DATE OF AGREED PLAN:** | | |
| **EMPLOYEE DETAILS** | | |
| Name: | | |
| Job Title: | | |
| Department: | | |
| Grade: | | |
| **LINE MANAGER DETAILS** | | |
| Name: | | |
| Job Title: | | |
| Department: | | |
| **MANAGER SUPPORTING RETURN TO WORK DETAILS (if different than above)** | | |
| Name: |  | |
| Job Title: | | |
| Department: | | |
| **PERIOD OF SICKNESS ABSENCE** | | |
| Start Date: | End Date: | |
| Reason: | | |
| **PHASED RETURN** | | |
| Details of phased return (if applicable): | | |
| Total number of annual leave days required to facilitate phased return: | | |
| Review date of phased return: | | |
| Name of manager conducting review: | | |
| **REASONABLE ADJUSTMENTS** | | |
| Has the employee attended Occupational Health Y/N | | |
| Have reasonable adjustments been agreed Y/N | | |
| Details of reasonable adjustments (if applicable): | | |
| Change of hours (perm/ temp)  Yes No  if yes, please detail the change of hours and whether this is temporary or permanent  Change of shift pattern (perm/ temp)  Yes No  if yes, please detail the change of shift pattern and whether this is temporary or permanent  Change of duties (perm/ temp)  Yes No  if yes, please detail the change of duties and whether this is temporary or permanent  Equipment required  Yes No  If yes, please detail what equipment is required  Other: | | |
| Does the employee consent to colleagues being advised of the reasonable adjustments? Y/N  If yes, is there any training or support that can be offered to colleagues?  If no, agree what information colleagues can be advised of. | | |
| Review date of reasonable adjustments: | | |
| Name of manager conducting review: | | |
| Comments/ Additional Information: | | |
| **Employee Signature:** | | **Date:** |
| **Line Manager Signature:** | | **Date:** |