**Central Montana Medical Center**

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| Top of FormBottom of Form**Employee Illness Log** |
| ATTENTION: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. |
| **Information must be recorded about every employee illness that occurs during the pay period that require days away from work. Illnesses include any sick call or event that has restricted employee work hours. They may or may not be diagnosed by a physician or licensed health care professional. This form MUST be completed EACH time an employee calls in sick. This form is to be completed by the Department Manager, or designee ONLY.** |
| **\*** | **Department Name:** |  |
| **\*** | **Employee Name:**Name of the employee that is calling in sick. |  |
| **\*** | **Name of staff member completing this form:** |  |
| **\*** | **Date employee called with illness:** |  |
| **\*** | **Date of illness onset:**if known. |  |
| **\*** | **Type of illness or related absenteeism:**Check ALL that apply | Fever / TempCoughSore ThroatHeadacheChillsFatigueMuscle achesRashN/VDiarrheaOpen Sore(s)Pink EyeOther |
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