

# Questionnaire absenteeism

Company:



**Steuerkanzlei**  
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Name of the employee

Personnel number

## illness

What kind of absence?	
<input type="checkbox"/> Continued payment of remuneration with certificate of incapacity for work	from _____ until _____
<input type="checkbox"/> Continued payment of remuneration without certificate of incapacity for work	from _____ until _____
<input type="checkbox"/> Sickness allowance in case of illness or cure	from _____ until _____
<input type="checkbox"/> Sick over 6 weeks marginally paid employee	from _____ until _____
<input type="checkbox"/> Sick privately insured without sickness allowance	from _____ until _____
<input type="checkbox"/> Sick at entry without continued pay	from _____ until _____
<input type="checkbox"/> Injury benefit in case of illness or cure	from _____ until _____
<input type="checkbox"/> Transitional allowance during illness or cure	from _____ until _____
<input type="checkbox"/> Sickness benefit in case of illness or cure	from _____ until _____
<input type="checkbox"/> Continued payment of remuneration due to organ/tissue donation	from _____ until _____
<input type="checkbox"/> others:	from _____ until _____
What was the last day of work before the illness?	at the:
Cause of incapacity for work	<input type="checkbox"/> Third party damage <input type="checkbox"/> Occupational accident
In case of cause damage by third parties: Assignment according to §5 AAG is declared	<input type="checkbox"/> yes <input type="checkbox"/> no
Was work still being done on the 1st day of incapacity?	<input type="checkbox"/> yes <input type="checkbox"/> no if yes, how many hours: _____

## Child care

<input type="checkbox"/> Child care with sick pay	from _____ until _____
<input type="checkbox"/> Child care without sick pay	from _____ until _____
<input type="checkbox"/> Child care with continued payment	from _____ until _____
<input type="checkbox"/> Child care in case of serious illness	from _____ until _____
Information about the child	
First name	
Date of birth	
Still working part time on first day of leave with full pay?	<input type="checkbox"/> yes <input type="checkbox"/> no

Cause of the illness is an accident (child injury benefit)?	<input type="checkbox"/> yes	<input type="checkbox"/> no
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### Maternity

Probable day of delivery:	At the:
Actual day of delivery:	At the:
Multiple birth: <input type="checkbox"/> yes <input type="checkbox"/> no	Premature birth: <input type="checkbox"/> yes <input type="checkbox"/> no
Earnings in the three months before the start of the protection period:	
month/year: _____ gross income: _____ net income: _____	
month/year: _____ gross income: _____ net income: _____	
month/year: _____ gross income: _____ net income: _____	
Was there secondary employment during these months? (Note: If you work for more than one employer, the maternity maternity benefit is determined on a pro rata basis per employment.)	<input type="checkbox"/> yes <input type="checkbox"/> no
Is there a ban on employment? <input type="checkbox"/> no <input type="checkbox"/> yes, from: _____ until: _____	
If yes, type of employment ban: <input type="checkbox"/> Individual employment ban <input type="checkbox"/> general ban on employment	

### Other absences

<input type="checkbox"/> parental leave	from _____ until _____
<input type="checkbox"/> care period	from _____ until _____
<input type="checkbox"/> Short-term care (up to 10 days)	from _____ until _____
<input type="checkbox"/> Care Support Allowance	from _____ until _____
<input type="checkbox"/> Unpaid leave	from _____ until _____
<input type="checkbox"/> Unpaid absence	from _____ until _____
<input type="checkbox"/> Irrevocable paid leave of absence	from _____ until _____
<input type="checkbox"/> Irrevocable unpaid leave of absence	from _____ until _____

\_\_\_\_\_

Date

\_\_\_\_\_

signature employer

