



ICL SUPPORT SERVICES LIMITED

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RESUMPTION OF DUTY CERTIFICATE

SURNAME:..... OTHER NAMES.....DATE OF EMPLOMENT.....

Department: Designation:.....

Date proceeded on leave:

Date of resumption of duty:

Approved leave period:

Type of Leave: Annual: Casual: Sick: Maternity:

Returned on the exact duly approved date: Yes: No: Signature/Date:

OFFICE USE (HUMAN RESOURCES)

Any days/period over spent? Yes: No:

Specify the period overspent:

RECOMMENDED ACTION:

Deduct from annual leave? Yes: No:

Issue warning: Suspension and no. of days:

Executing/Personnel officer:
Name, signature and date

Supervising Head of Unit:
Name, signature and date

Action:

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Head, Human Resources/ Authorized Signature