Manitoba Association of HEALTHCARE Professionals

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Medical Certificate

The form of this document has been approved for use by the Manitoba Association of Health Care Professionals.

The contents of this certificate are to be used by the Employer and distributed only as required for the employee to access leave and/or benefits due to illness or injury, and are subject to strict confidentiality and privacy rights.

PART 1 – Authorization for Release of Medical Information (to be completed by the employee)

I _____ hereby authorize my physician to complete the Physician's Statement below and to release this medical certificate to:
(circle one)

Me — Employer
My Union/Lawyer — Insurance company

Date: _____ _____
Signature of Employee

PART 2 – Physician's Statement (to be completed by the attending physician)

Please clearly fill in all pertinent areas and sign the completed certificate. By signing this certificate you agree that the information provided is complete and accurate, to the best of your knowledge.

1. The employee's date(s) of examination regarding this illness/injury was on _____.

2. Is medical leave required by the employee? (Circle only one) Yes No

3. Without giving a specific diagnosis, state the general nature of the employee's illness/injury requiring medical leave?

_____

_____

_____

_____

4. a) Has a treatment/remedy plan been prescribed to the employee?
(Circle only one) YES NO

b) If yes, is the employee fulfilling the treatment/remedy plan?
(Circle only one) YES NO

5. What medical follow-ups, if any, are occurring relating to the employee's illness/injury? _____
_____
_____
_____
_____

6. Have you referred the employee to a specialist or other healthcare practitioner regarding their illness/injury?
(Circle only one) YES NO
If yes, who? _____

7. What is the estimated date that the employee will be able to return to work:
_____

8. a) Do you anticipate any restrictions on the employee upon their return to work? (Circle only one) YES NO

b) If yes to a), explain the restrictions: _____
_____
_____
_____
_____
_____

c) The anticipated duration of these restrictions will be _____
_____
_____

Date: _____ _____
Day/mo./year Signature of Physician

_____
(Please print name)