Manitoba Association of HEALTHCARE Professionals

101-1500 Notre Dame Ave.
Winnipeg MB
R3E 0P9
Phone: 1-204-772-0425
Fax: 1-204-775-6829
Info Line: 1-800-315-3331
Website: www.mahcp.ca

Sickness Certificate

Patient Name: _____

1. Fitness to work

   I confirm that the above is fit to return to work.

   Yes____ No____

   If No, I estimate the return to work by _____

2. Illness (complete this section only with specific consent of patient)

   On the basis of my review, I conclude that the patient was ill during the time noted above.

   Yes____ No____

   Check only statement(s) which apply:

   _____ Review include Patient History

   _____ Review includes Examination

   _____ Objective Evidence Confirmed (signs or investigational data)

3. Duration of Absence, According to the Patient from _____ to _____ Inclusive.

Name of Physician _____
(Print)

Physician's Signature _____

Date _____