Brock University
Attending Physician's Statement

A. Employee and Employer Information (to be completed by Employer or Employee)

Employee's Last Name	First Name .	Home Phone ( )	
Address	City/Town	Province	Postal Code
Date of Birth	Gender ☐M ☐F ☐	Name of Physician	Physician's Phone Number
Employee Job Title/Occupation	Employer Contact Name Zoe Vulic, BA Kin	Position Manager, Health Management	
Employer Phone (905) 688-5550 ext. 4237	Employer Fax (905) 688-8481	Employer E-mail zvulic@brocku.ca	

B. Authorization for Release of Information (to be completed by Employee)

By signing below, I consent to allow the physician completing this form to provide information to the Brock University Health Management Office concerning the specific absence from work identified in this form, for the relevant purpose(s) of determining eligibility for income replacement benefits; approving an unpaid medical leave of absence; and/or facilitating an early and safe return to work. I understand that all information will be treated in a highly confidential manner and only information regarding my return to work and any related limitations and accommodations will be shared with my Supervisor. I agree that a facsimile copy or a photocopy of this form and any related documents will be considered as valid, original copies.

Employee's Signature	**Date**

C. Information to be Completed by Physician

How does the illness / injury affect the employee's ability to work:

Is the condition arising from employment? □ Yes □ No

First day employee unable to work:

Please provide a general overview of the general components and estimated duration of the treatment plan, without reference to the employee's diagnosis:

Has the employee been referred to a specialist licensed to practice medicine in Ontario? □ Yes □ No	Date of referral:

To your knowledge, is the employee compliant with the recommended treatment plan? □ Yes □ No
Explain:

Is the employee under your active and continuous care:	□ Yes □ No
Prognosis for Return to Work:	

Brock University is able to provide suitable modified duties / hours when medically supported to avoid prolongation of absence from the workplace and to ease the employee's reintegration into the work environment.

Is the employee capable of returning to modified duties: □ Yes □ No If yes, effective when: _____
Does the employee require modified hours: □ Yes □ No

Please outline any specific restrictions to assist the University with appropriate accommodation:

What is the estimated duration of the restrictions: _____

Expected return to work (full duties) date: _____

Additional Comments:

D. Physician's Information
By affixing my signature below, I certify that I am a qualified medical health professional and that I have personally assessed and treated the above patient/employee.

Physician's Name: (please print):				
Specialty:				
Address				
City/Town	Province	Postal Code	Phone Number ( )	FAX # ( )
The information in this statement will be kept in the employee's confidential health management file at Brock University and will only be accessible by the employee and Brock University's Health Management Office.				
Physician's Signature			Date	

Note: The employee is responsible for payment to the physician for completion of this form when requested by the University. The reimbursement of the physician's fee for the completion of this form, if any, is subject to and governed by the applicable collective agreement or University policy.