Brock University
Request for Medical Accommodation

A. Patient 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	Sex ☐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 illness/injury identified in this form, for the relevant purpose(s) of determining eligibility for income replacement benefits; approving an unpaid medical leave of absence; facilitating an early and safe return to work; and/or working toward a temporary or permanent accommodation of work restrictions. 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

Nature of Illness/Injury:

Impairments as a Result of the Condition:

First visit pertaining to this illness:	First day requiring accommodation:

Does patient participate in ongoing treatment: ☐Yes ☐ No

Please provide a general description of the treatment plan:

Name of Treatment Providers:

Dates of Treatment (at your office):

Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Date of follow-up appointment:

Has your patient reached maximum medical recovery: □ Yes □ No

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 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 patient or third parties to whom access has been granted.				
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.