

## **MEDICAL CERTIFICATE**

The form of this document has been approved for use by 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.

<b>PART 1 – Authorization for Release of Medical Information</b> (to be completed by the employee)
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I \_\_\_\_\_ hereby authorize my physician to complete the Physician's Statement below and to release this medical certificate to (circle one)

- Me
- My Union/Lawyer
- Employer
- Insurance company

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Employee

<b>PART 2 – Physician's Statement</b> (to be completed by the attending physician)
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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 if 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, Month , Year

\_\_\_\_\_  
Signature of Physician

\_\_\_\_\_  
Name of Physician (Please print)