Patient's Given Name	
Patient's Date of Birth (DD/MM/YYYY)	

Daily quantity of medication to be used by the patient per day:

The period of use is _____days(s) _____week(s) _____month(s)
NOTE: The period of use cannot exceed one year.

The following are the symptoms or the functional limitations associated with the treatment plan that may prevent the employee from completing his/hers duties as a _____ (enter position) safely.

Can this person work on a part-time, modified work or on a restricted basis? ☐ Yes ☐ No

Health Care Practitioner's given name and surname	
Health Care Practitioner's Profession	
Health Care Practitioner's Business Address	
Full business address of the location at which the patient consulted the Health Care Practitioner (if different from above)	
Phone Number	
Fax Number	
Email Address	
Province(s) Authorized to Practice In	

By signing this document, the Health Care Practitioner is attesting that the information contained in this document is correct and complete.

Health Care Practitioner's Signature	
Date Signed (DD/MM/YYYY)	

Office Use:

_____ Received by

_____ Title

_____ Date

cc: Employee
Employee file