MEDICAL CERTIFICATE

Fax:
Claims Management/Return to Work 306-446-6020
Attendance Support Program 306-446-6020

**NOTE: This is the only form Prairie North Health Region recognizes and accepts for absences from work due to injury/illness. This form can be obtained from your employer or family physician. PNHR is not requesting diagnosis but will request prognosis to ensure the return to work is completed in a safe, healthy and timely manner.*

I authorize all physicians and medical practitioners involved in the assessment, investigation and treatment of the medical condition(s) affecting absence from work to provide PHNR with the information required for them to ensure my safe and timely return to work. I hereby permit and authorize my employer to receive a summary of my functional status including all restrictions, limitations and/or modifications necessary to implement my safe return to work. I agree to remain available for work and will perform modified work that is within my limitations and restrictions provided such modified work is approved by a licensed medical practitioner.

_____	_____	_____	_____
Employee Name (Print)	Employee Signature	Date	Job/Facility

This Release applies only to the current medical condition.

Date assessed by physician: (DD/MM/YYYY) _____

Nature of Illness: (A general statement of a person's illness or injury in plain language without any reference to diagnosis and symptoms) _____

Is the illness or injury ☐ **WORK RELATED** ☐ **NON WORK RELATED**

Is the absence medically required: ☐ **Yes** ☐ **No**

WORKER CAN WORK WITH RESTRICTIONS:

Prairie North Health Region is willing to provide temporary accommodations for all workers based on objective medical findings from a physician. **In your opinion, are there workplace accommodations or modifications that would allow your patient to continue work?**

☐ YES ☐ NO

Please identify physical restrictions based on worker's job and you objective medical assessment:

If there are no restrictions indicated, we will assume that the worker is able to return to regular duties without any job modifications.

☐	Standing (prolonged > 45min. without opportunity for break)	☐	Lifting (# of lb/kg)	☐	Environment (exposure heat/cold working outside)
☐	Sitting	☐	Push/pull	☐	Stooping/bending forward
☐	Reaching	☐	Stair climbing	☐	Squat/awkward position

☐ Reduction in hrs/shift *(specify)*:_____

☐ Other *(if behavioural/psychological, please refer to appropriate health care provider)* _____

DATE OF ANTICIPATED RETURN TO FULL DUTIES_____

WORKER UNABLE TO WORK AT ALL:

Is it your medical opinion that the worker is too ill to perform any tasks related to his/her job? ☐ Yes ☐ No

LENGTH OF TOTAL DISABILTY TIME: Number of days _____ **OR** Number of shifts _____

ADDITIONAL COMMENTS: _____

_____

NAME OF PHYSICIAN/HCP _____ SIGNATURE (Physician/HCP):_____ DATE: _____
(Please Print)

PRAIRIE NORTH HEALTH REGION IS NOT RESPONSIBLE FOR ANY COSTS RELATED TO OBTAINING AND COMPLETING OF MEDICAL CERTIFICATE(S).