JOSEPH BRANT HOSPITAL

To be completed by the Employee:

Department: ______________________

Manager: ________________________

NON-OCCUPATIONAL ILLNESS/INJURY CERTIFICATE

Employee Name: ____

Period of illness: From: (DD/MM/YY)________________To: (DD/MM/YY) ________________

This patient has presented to me seeking medical advice relative to ill health. On the basis of the history provided, the patient reported that he/she would have been required to have been off work during the time indicated above.

Yes No

I can confirm the patient’s illness based on the direct examination or management of the patient during the period indicated above.

Yes No

Based on the information provided to me, the patient is capable to return to the work place.

Yes No

The review of information may have included:

- ☐ Workplace issues/Exposures
- ☐ Patient’s Medical History
- ☐ Current Health Concerns
- ☐ Objective Evidence (signs/investigational data)

Physician’s Name: ______________________________

Physician’s Signature: ______________________________

Date: ______________________________

STAMP