Rainy River District Social Services Administration Board

MEDICAL Leave of Absence Form

Attending Physician Information		
Name of Health Organization:		
Name of Physician:	Address:	
Town:	Postal Code:	Phone:

Please assess the employee and complete the following:

This is to certify that ________________________________ has been assessed and was
(Name of Employee)

absent due to medical illness/injury from: _______________ to: _______________ inclusive.

As of ____________________________________, this employee (*check one*):
(Date)

- ❑ may return to Full Duties
- ❑ may return to Modified Work
  (A *Functional Abilities Form* must be completed listing restrictions/capabilities/limitations)
- ❑ remains Unable to Work at this time

Physical Comments: ____

____

Date: _______________________ Attending Physician: _________________________

Please send this completed form to:

Rainy River District Social Services Administration Board
ATTENTION: Human Resources – PRIVATE AND CONFIDENTIAL
450 Scott Street
Fort Frances, ON P9A 1H2
Phone: (807) 274-5349 Fax: (807) 274-0678

Information Contained on this Form is to be placed in the Employee Health File and remain Confidential.

Sept, 2014