



Verification of Sickness Form

Part 1: Patient Identification

Last Name

First Name

Part 2: Attending Physician's Statement

1. General nature of illness or injury _____

2. Duration of absence from work:

From _____ to _____ inclusively.

3. Based on the information provided to me, the patient is fit to return to work.
Circle Yes or No and enter the appropriate date.

Yes Return to work date: _____

No Date of medical review: _____

On the basis of my review of the patient's illness/injury, I conclude that the patient would have been required to be off work for the time noted above.

Review limited to patient's history or Objective evidence confirmed

Physician's Signature:

Physician's Name and Address (Please print or use stamp):

Date: _____

If you have any questions, please feel free to contact us directly at 204.786.9060.

Please provide the information directly to Employee Health and Wellness at:

- Human Resources, 7th Floor Rice Building
- Email: employeehealth@uwinnipeg.ca
- Please call or email ahead to fax to: 204.774.2935

Any costs associated with the completion of this form are the responsibility of the patient.