



THE UNIVERSITY OF WINNIPEG

Verification of Medical Leave & Return-to-Work (RTW) Clearance Form

Part 1: Patient Identification (employee to complete)

Employee Name:

Employee DOB:

Part 2: Consent to Release Information (employee to complete)

I, _____ (employee), authorize my physician/healthcare provider to disclose to the Wellbeing Office at The University of Winnipeg the medical/functional information necessary to assess my fitness for work and any work restrictions or limitations, for this request only.

Employee Signature:

Date:

Part 3: Attending Physician's Statement (physician to complete)

1. General nature of illness or injury: _____
2. Duration of absence from work: From _____ to _____ inclusively.
3. Employee is participating in a treatment plan: Yes No If no, reason: _____
4. **RTW Guidance:** Due to injury, illness, or disability, this employee is:

Not fit to return to work, even with accommodation.

Readiness to return to work will be reassessed on _____ (date).

Fit to return with **Full** or **Modified** duties as of _____ (date).

If modified duties are recommended, please complete questions **a** through **c** below:

a. **Full hours** **Graduated hours**

b. **RTW Restrictions/Limitations:** (Restriction: an activity that the individual is medically advised not to perform in any capacity. Limitation: an activity that may be performed in a reduced capacity.)

c. **Expected Duration of Restrictions/Limitations**

Until (date or number of weeks/months) _____

Unsure – date of reassessment: _____

Permanent

Practitioner name (print):

Signature:

Specialty:

Date:

Please return this form to Wellbeing at wellbeing@uwinipeg.ca, or by fax to 204.774.2935.

Costs associated with completing this form are the patient's responsibility.