REGINA

MEDICAL CERTIFICATE
EMPLOYEE ABSENCE FROM WORK FORM

HEALTHCARE PROVIDERS: Please send completed form and invoice via **email to HRAdmin@regina.ca** or **fax to City of Regina 306-777-6825**

REASON FOR VISIT: ❑ **Workplace Injury** ❑ **Personal Injury/Illness**

Date of Injury/Illness (D/M/Y): / /

Employee Last Name:	Employee First Name:	Employee ID Number:
Contact Phone Number:	Dept./Branch:	Name of Supervisor:

THIS SECTION TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER

Date of current visit (D/M/Y): / /

Date Employee can return to regular duties (D/M/Y): / /

EMPLOYEE RESTRICTIONS (IF APPLICABLE)
(Modified Duties are Available)

Date Employee can return to modified duties (If restrictions can be met) (D/M/Y): / /

❑ standing ❑ sitting ❑ lifting (# of lbs/kg)______ ❑ overhead or forward reaching ❑ kneeling/crouching

❑ walking ❑ driving ❑ operating equipment ❑ ladders ❑ pushing/pulling ❑ neck/trunk movement

❑ bending ❑ stairs ❑ computer/data entry ❑ mental health

❑ environment (cold/hot weather, dust/fumes, etc)___________ ❑ Hours of work (please specify):____________________

Can the employee work overtime? ❑ yes ❑ no

Date of reassessment (D/M/Y): / /

Additional Restrictions/Limitations (Do not include any diagnosis): ______________________________

Additional Referral (ie. Specialist)

Physician's Name & Address:	Signature:	Date:
Reviewed by Supervisor:	Signature:	Date:

For purposes of confidentiality, please ensure that the completed form is handled in a senstive manner and delivered to the City of Regina's Human Resources Department-Healthy Workplace.