Patient's Given Name			
Patient's Date of Birth (DD/MM/YYYY)			
Daily quantity of medication to be used by the patient per day:			
The period of use is _____days(s) _____week(s) _____month(s) **NOTE: The period of use cannot exceed one year.**			
The following are the symptoms or the functional limitations associated with the treatment plan that may prevent the employee from completing his/hers duties as a _____ (enter position) safely.			
Can this person work on a part-time, modified work or on a restricted basis?		Yes	No
Health Care Practitioner's given name and surname			
Health Care Practitioner's Profession			
Health Care Practitioner's Business Address			
Full business address of the location at which the patient consulted the Health Care Practitioner (If different from above)			
Phone Number			
Fax Number			
Email Address			
Province(s) Authorized to Practice In			
By signing this document, the Health Care Practitioner is attesting that the information contained in this document is correct and complete.			
Health Care Practitioner's Signature			
Date Signed (DD/MM/YYYY)			

Office Use:

Received by: _____ Title: _____ Date:_____

Cc: Employee
Employee file