

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)					
<b>NOTE: The period of use cannot exceed one year.</b>					
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?			<table border="1"> <tr> <td>Yes</td> <td>No</td> </tr> </table>	Yes	No
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					
<b>By signing this document, the Health Care Practitioner is attesting that the information contained in this document is correct and complete.</b>					
Health Care Practitioner's Signature					
Date Signed (DD/MM/YYYY)					

Office Use:

Received by: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

Cc: Employee  
Employee file