Schedule B - Application for Sick Leave & Income Protection Benefit & Return to Work Authorization

Instructions:

1. *It is the employee's responsibility to have this form completed and every reasonable effort should be made to have this returned to his/her non-union supervisor on return to work, or as requested.*
2. *Section B, question 2 or 3 must state your exact return to work date.*
3. *If there is change in your ability to perform your normal job, it is important to have Section B completed and give it to your non-union supervisor within 10 calendar days of first day of sick leave.*

- PHYSICIAN: THE FOLLOWING CONFIDENTIAL INFORMATION IS NECESSARY TO PROCESS OUR EMPLOYEE'S CLAIM FOR SICK LEAVE PAY AND TO ASSIST US IN PLANNING WITH RESPECT TO HIS/HER ABILITY TO RETURN TO WORK. PLEASE RETURN COMPLETED FORM TO YOUR PATIENT.

SECTION A: *TO BE COMPLETED BY EMPLOYEE*

NAME_____**EMPLOYEE NO.**_____

JOB TITLE_____**DEPT.**_____

WORK LOCATION_____**SUPERVISOR'S NAME**_____

DATE OF 1ST DAY ABSENT_____

NATURE OF ILLNESS_____

This signature authorizes the undersigned physician(s) to release information concerning my present medical condition to the CBRM/Occupational Heath Nurse or Doctor.

EMPLOYEE'S SIGNATURE_____DATE_____

SECTION B: TO BE COMPLETED BY ATTENDING PHYSICIAN

1. THIS EMPLOYEE HAS BEEN ABSENT FROM WORK AND UNDER MY CARE FROM _____ TO_____
2. HE/SHE MAY RETURN TO WORK ON_____WITH NO RESTRICTIONS
3. HE/SHE MAY RETURN TO MODIFIED WORK ON_____UNTIL_____WITH THE FOLLOWING RESTRICTIONS_____

_____

SECTION C: *TO BE COMPLETED BY ATTENDING PHYSICIAN* **CONFIDENTIAL**

4. **NATURE OF ILLNESS**_____

_____

DATE OF ONSET_____**DATE OF FIRST EXAMINATION**_____

☐ **OFF THE JOB INJURY** ☐ **ILLNESS**

PRESENT TREATMENT_____

_____

DATE HOSPITALIZED **DAY**_____**MONTH**_____**YEAR**_____

IF REFERRED, TO WHOM_____**DATE**_____

5. **PROGNOSIS OR ADDITIONAL COMMENTS**_____

_____

6. **NAME AND ADDRESS OF PHYSICIAN** (please print)_____

_____

7. **NAME AND ADDRESS OF PHYSICIAN** (please print)_____

_____

PHYSICIAN'S SIGNATURE_____ **Date** _____

Where an employee deems information in Sections B & C to be confidential, they can return same to non-union supervisor in a sealed envelope marked "MEDICAL REPORT" addressed to CBRM Occupational Health Nurse c/o HR Department or deliver directly to the CBRM HR Department.