VICTORIA UNIVERSITY
IN THE UNIVERSITY OF TORONTO

MEDICAL REPORT

Victoria University is committed to assisting employees to return to work after injury or illness and to providing work accommodation where medically required. Section A: to be completed by Employee. Section B: to be completed by physician.

NOTE: ANY COST FOR COMPLETION IS THE EMPLOYEE'S RESPONSIBILITY

SECTION A – MUST BE COMPLETED BY EMPLOYEE **Name of treating physician and signature required on page 2**

I authorize _____(Treating Physician's name and address or stamp) to communicate both verbally and in writing with Health & Well-being Programs and Services, Human Resources, Victoria University, for purposes of discussing the information provided in this report. I also consent to the release of the information in this form to Human Resources, Victoria University, Sun Life Financial and WSIB for the purpose of assessing my entitlement to any benefits and administering those benefits, and for the purpose of assessing my ability to return to work,

EMPLOYEE SIGNATURE : **Date:**

Surname	First Name	Date of Birth:
Address	City /Town	Province / Postal Code
Date Last Worked	Job at Time of Illness	Phone Number

SECTION B – TO BE COMPLETED BY TREATING PHYSICIAN

Date first unable to work: DD/MM/YR_____/_____/_____ Is this a work-related injury? ☐Yes ☐No	Describe the nature of the primary disabling illness or injury. Is the absence related to workplace issues? ☐ YES ☐ NO If Yes, please provide details:
Describe current clinical signs and symptoms and how these are preventing the employee from returning to work	
Describe current treatment plan and goals	
Date of first and all subsequent visits during present period of absence from work DD/MM/YR_____/_____/_____	Referred to a Specialist? ☐ YES ☐ NO If Yes please provide details below: _____ Name of Specialist Address Appointment Date (DD/MM/YR)

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73 Queen's Park Cres. Toronto ON M5S 1K7
Fax: 416-921-4556

Date of next appointment: DD/MM/YR_____/_____/_____ If condition is a complication of pregnancy, what is the expected date of delivery? DD/MM/YR_____/_____/_____	Does employee require further treatment? ☐ YES ☐ NO Describe: _____ _____ _____ Duration_____week/s Frequency_____per week

Is Employee Fit to Return to Work? ☐ YES ☐ NO If **yes**, please specify: ☐ REGULAR WORK
☐ MODIFIED WORK – Please provide details below

If **YES**, please specify date able to return__/_____/_____ ☐ MODIFIED HOURS – Please provide details below DD MM YY

If **NO**, is there a prognosis for a return to work date?_____/_____/_____ DD MM YY

PLEASE INCLUDE EXPECTED DURATION OF MODIFIED DUTIES OR HOURS :

PHYSICAL RESTRICTIONS UPON RETURNING TO WORK

LIFTING
- ☐ Not over 5 lbs
- ☐ Not over 10 lbs
- ☐ Not over 20 lbs
- ☐ Not over 30 lbs
- ☐ Not over 40 lbs

PUSHING/PULLING
- ☐ Not over 5 lbs
- ☐ Not over 10lbs
- ☐ Not over 20 lbs
- ☐ Not over 30 lbs
- ☐ Not over 40 lbs

CARRYING
- ☐ Not over 5 lbs
- ☐ Not over 10 lbs
- ☐ Not over 20 lbs
- ☐ Not over 30 lbs
- ☐ Not over 40 lbs

GRASPING/GRIPPING
- ☐ Minimize repetitive use
- ☐ Right hand
- ☐ Left hand

LIMBS/BACK
- ☐ Minimize repetitive use
- ☐ Minimize twisting or bending
- ☐ Limited reaching, pushing, and pulling
- ☐ Limited above shoulder reaching

TOOLS AND MACHINES
- ☐ No motor vehicle, crane or elevator
- ☐ Must not operate selected machines:

MOBILITY
- ☐ No prolonged standing
- ☐ No prolonged sitting

EYES/EARS
- ☐ Restricted use, see details

SKIN
- ☐ Avoid contact with _____
- ☐ Must wear specific protective devices (e.g. non-latex gloves) _____

OTHER RESTRICTIONS: (including cognitive if appropriate)

Is the employee involved in any treatment or taking any medication that may affect ability to work? ☐ YES ☐ NO (If Yes, describe the impact)

Are there any other medical reasons that preclude the employee from returning to work? ☐ YES ☐ NO (If Yes, please explain)

Would specialized assistive devices/equipment/assessment be beneficial in this case? ☐ YES ☐ NO, If yes, please provide details:

Physician's Name (please print)	Address	Phone
Physician's Signature		Date of Report

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