Guysborough Antigonish Strait Health Authority
25 Bay Street, Antigonish, NS B2G 2G5

ATTENDING PHYSICIAN STATEMENT

Physician: Please complete the following information to assist in reviewing this employee's ability to work.

Patient's Name: _____

Address: _____ **Phone:** _____

Please describe patient's present health:

_____

_____

_____

Additional conditions or complications which might affect periods of absences from work:

_____

_____

Treatment Plan:

_____

_____

If referral to Specialist Appointment date (dd/mm/yyy) ___/__/____

Specialist's Name: _____ Specialty: _____

Prognosis: _____

Is Employee fit to return to work at this time? € Yes € No

If no: Estimated return to work date? (dd/mm/yy) _____/_____/_____

If Yes: € Full Duties € Modified Work Please specify limitations/restrictions:

_____

_____

_____

The employee will be reassessed (dd/mm/yyy) _____/_____ /_____

Physician Name: _____ Address:_____ Phone: _____

Physician's Signature: _____ Date: _____
dd/mm/yy

I hereby authorize the release of this information requested with respect to my ability to work. The information will be kept in the confidential employee health file and only information regarding ability to work will be released to the employer.

Employee's Signature: _____ **Date:** _____

Please return to: GASHA Occupational Health Services
Phone: 902- 867-4500 ext. 4101 Confidential Fax: 902-863-6455