Proof of Illness

PLEASE NOTE: COSTS ASSOCIATED WITH THE COMPLETION OF THIS FORM ARE THE RESPONSIBILITY OF THE EMPLOYEE

EMPLOYEE TO RETURN COMPLETED PROOF OF ILLNESS FORM TO MANAGER/SUPERVISOR

*Please have your physician complete this Proof of Illness form for an absence from work in the event of an illness or injury. Please return this form to your manager/supervisor **completed in full.***

PART A: TO BE COMPLETED BY EMPLOYEE

Employee's Name	Employee Number	Phone Number	First Shift Missed (MM-DD-YY)

I hereby consent to my physician completing this Proof of Illness form to assist my manager/supervisor in return to work planning and benefit administration.

EMPLOYEE'S SIGNATURE

DATE (MM-DD-YY)

PART B: TO BE COMPLETED BY PHYSICIAN

NATURE OF MEDICAL ABSENCE	DATE OF ONSET OF ILLNESS/INJURY (MM-DD-YY)	ANTICIPATED LENGTH OF ABSENCE
☐ ILLNESS/INJURY ☐ WSBC CLAIM ☐ ICBC CLAIM		
DATE OF INITIAL ASSESSMENT (MM-DD-YY)	DATE OF REASSESSMENT (MM-DD-YY)	**DATE OF RETURN TO FULL DUTIES (MM-DD-YY)**

Please advise if your patient will require the assistance of disability management for return to work planning. For example, modified duties and/or a gradual return to work:

- ☐ YES
- ☐ NO

PHYSICIAN'S NAME (PRINT)	PHYSICIAN'S SIGNATURE	DATE (MM-DD-YY)

PHYSICIAN'S STAMP

PART C: TO BE COMPLETED BY MANAGER/SUPERVISOR

MANAGER/SUPERVISOR'S NAME (PRINT)	MANAGER/SUPERVISOR'S SIGNATURE	DATE RECEIVED (MM-DD-YY)

Note to Manager/Supervisor: Please retain this Proof of Illness form in your confidential file. For any questions and/or concerns, please follow up with your Human Resources Consultant.