

CERTIFICATE OF ILLNESS

Patient Name: _____

Duration of Absence:

From (according to patient): _____

To (according to physician): _____

1. FITNESS TO:

(CHECK ALL THAT APPLY)

Work

Attend Class

Complete Assignments

Write Examinations

I confirm that the above is fit to return to duties: Yes No

In a Limited Capacity (please specify limitations):

If NO or Limited Capacity, I estimate that he/she will return to full-time duties by

2. ILLNESS:

(COMPLETED WITH PATIENT'S CONSENT)

On the basis of my review, I conclude that the patient was ill during the time noted above. This review includes:

Patient History

Examination

Objective Evidence Confirmed (signs or investigational data)

Physician's Signature

Date

NB: This certificate is considered official if it bears a University of Manitoba Health Service Stamp. In the event that an examination was missed or course requirement was unfulfilled during the above certified illness, the Student must contact the appropriate School or Faculty to arrange for completion of course requirements. Regulations regarding deferred examinations will vary from faculty to faculty.