City of Welland
Corporate Services
Human Resources
60 East Main Street, Welland, ON L3B 3X4
Phone: 905-735-1700 Ext. 2271 | **Fax:** 905-734-7608
Email: hr@welland.ca | www.welland.ca

DOCTOR'S REPORT OF ILLNESS/INJURY

As the Corporation of the City of Welland self-insures for the first twenty six (26) weeks of disability, the Corporation requires medical certification of the disability. Please Note: The Doctor's Report of Injury/Illness Form (DRI) is the only acceptable non-occupational medical form accepted by the Corporation. Other notes or forms from medical doctors or health care practitioners will not be accepted.

Employee Section:

_____ _____ _____
Employee Name Position Employee I.D. Number

_____ _____
Current Contact Telephone Number Supervisor

I, _____ hereby authorize my physician to supply the following medical information to the Human Resources Department of the City of Welland. I agree that a photocopy of this authorization be considered as valid as the original.

EMPLOYEE SIGNATURE: _____

Medical Doctor/ Health Care Practitioner Section:

Employee to return completed form directly to Human Resources (electronically or in a sealed envelope).

Date of Assessment: _____ Date of Injury/Illness: _____

Nature of Illness/Injury: Non-occupational ❒ Occupational ❒ Unknown ❒

General description of illness/injury:

_____

Have you treated this employee for this condition in the last 30 days? Yes ❒ No ❒ If yes, when? _____

Is this a re-occurrence of a previous disability? Yes ❒ No ❒ Date of Previous Disability: _____

Date of Next Medical Appointment: (if applicable) _____

Is the employee capable of returning to work? Yes ❒ No ❒

If yes, please complete the City of Welland Functional Abilities (FAF) Form.

Capability of Returning to Full/Modified Duties and/or Hours (Please Check Only One Box)

Full Duties ❒ Modified Duties ❒ Unable to Return to Work ❒

Return to Work Date: _____

Additional Comments:

_____

Name of Physician: _____ Date: _____
(Please Print)
Address: _____ Telephone: _____

PHYSICIAN SIGNATURE: _____

The City of Welland recognizes that a temporarily disabled employee can and should be performing meaningful, productive duties. The City of Welland is committed to working with you the physician to return the employee back to an early and safe return to work.