CITY OF ST. CATHARINES

Release of Medical Information Form

I,_____, hereby authorize my Medical Doctor / Health
(Please Print Employee Name)

Care Practitioner, _____ to provide clarification with
(Print Doctor / Health Care Practitioner Name)

respect to the information provided on the Injury / Illness Status Report (ISR)

dated: _____ to the Human Resources Department of

the City of St.Catharines as it relates to my current medical absences from work,

my ability to return to work with modified duties and my employment obligations.

I further authorize a Human Resources representative to contact my Doctor /

Health Care Practitioner should further clarification of my current absence and/or

return to work status be required.

_____ _____

Signature of Employee Date