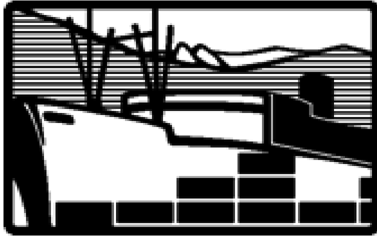

International
LONGSHORE & WAREHOUSE UNION

LOCAL 500

WORK ID #

PHYSICIAN'S REPORT

Employee Name:	Phone Number:
Address:	Work Number:

TO BE COMPLETED BY YOUR PHYSICIAN:

Physician Information

Physician Name:	Phone Number:
Address:	

Date of Examination:	Date of Illness/Injury:
Description of Illness/Injury:	
Expected Duration of Illness/Injury:	
Date Employee Stopped Working:	Date Employee Returned to Work:
Place Accident/Injury Occurred:	
☐ ICBC ☐ WCB ☐ Insurance	Claim Number:

Doctor's Signature: ______________________ Date: ________________________
(form must have Doctor's stamp)

Any worker caught falsifying records will be subject to discipline, up to and including deregistration.

Employee Signature: _________________________

SPACE FOR OFFICE USE ONLY: