COVID-19 Assessment Centre

Physician Recommendation

Today's Date: _____

Name: _____

Date of Birth: _____

Check appropriate choice below:

☐ Self-Isolate

To Whom it May Concern:

This is to certify the above patient is to remain **off work** and self-isolate until _____.
Date

☐ Return to Work as of _____.
Date

_____ _____

Physician Name (printed) **Physician Signature**

If any questions/concerns please contact Telehealth Ontario 1-866-787-0000

WINDSOR REGIONAL HOSPITAL
OUTSTANDING CARE – NO EXCEPTIONS!

ACCREDITED WITH EXEMPLARY STANDING
ACCREDITATION AGRÉMENT CANADA

COMPASSION is our PASSION

OUR VISION: OUTSTANDING CARE - NO EXCEPTIONS!
OUR MISSION: DELIVER AN OUTSTANDING PATIENT CARE EXPERIENCE BY A PASSIONATE COMMITMENT TO EXCELLENCE