



# MSI-21

## TEMPORARY WORK ASSIGNMENT

(Please print clearly in ink)

### SECTION A – WORKER INFORMATION

Worker's Name \_\_\_\_\_ SIGNATURE: \_\_\_\_\_  
(Last name first, in full)

Phone No. \_\_\_\_\_

Address \_\_\_\_\_  
(Street Number and Name) (Town) (Province) (Postal Code)

Position Title: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

### SECTION B – EMPLOYER INFORMATION

Name of Employer: \_\_\_\_\_

Contact Person: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Telephone #: \_\_\_\_\_

### SECTION C – NATURE OF THE TEMPORARY ASSIGNMENT

DESCRIPTION: (posture, movements, work schedule etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PHYSICIAN NAME: \_\_\_\_\_ PHYSICIAN NUMBER: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_ Date | | | | | | | | | |

Day Month Year