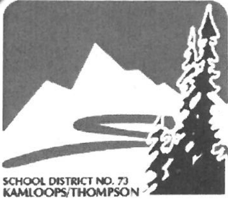

SCHOOL DISTRICT NO. 73 (KAMLOOPS/THOMPSON)
1383 Ninth Avenue Kamloops BC V2C 3X7
Phone: (250) 374-0679 • Fax: (250) 372-1183

MEDICAL CERTIFICATE

PRIVATE AND CONFIDENTIAL

PLEASE PROVIDE PHYSICIAN NAME & CONTACT INFORMATION HERE:

Employee's Authorization for Release of Information

I, ____________________ hereby authorize my physician to release this medical certificate to School District No 73 Human Resources (the "employer")

Employee Signature: ______________________________ *Date:* ___________________________

PART A – To be completed by the Physician

1. Are you actively treating this patient? Yes ________ No_______

2. Please list the dates of visits related to the current medical condition:
____
____

3. What is the general nature of the medical condition?
____
____
____

4. Has this patient been referred to a medical specialist? Yes ________ No_______

5. Is the patient receiving treatment? Yes ________ No_______

6. Is the patient compliant with treatment? Yes ________ No_______

7. The patient's expected date of return is: ______________________________ unknown: ☐

If the date of return is unknown, please answer below and sign the form as complete:

- Date of re-assessment:____
- Estimated date of return:____
- Prognosis for returning:____

Physician Signature: ____________________________________ Date: ___________________

If the patient's expected date of return is known, please complete the following pages.

Revised: March 11, 2015