



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

Patient Name: _____ DOB: _____

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: _____



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

PART B - To be completed by the Physician

1. Please indicate the following regarding your patients' return:

- Full-duties _____ Modified duties _____ Gradual return to work _____
- Estimated date of return to full-duties: _____
- Prognosis for returning to full-duties: _____

2. What physical or psychological manifestations should the employer know in order to monitor and assess the effectiveness of adaptation(s)/modification(s) in the workplace?

3. Do you recommend any adaptation(s)/modification(s) to the workstation/workplace?

4. Are there current modalities of treatment that the employer needs to be aware of (i.e. medicinal side effects, rehabilitation appointments, other)?

5. Please specify if there are any environmental restrictions for this patient (i.e. Heat/cold, dust/fumes/odours, chemicals, allergies, other)?

6. Please complete the following attachments and sign the form as complete.

ATTACHMENT 1 – If your patient has a disability requiring physical restrictions.

ATTACHMENT 2 – If your patient has disability requiring psychological/cognitive restrictions.

Physician Signature: _____ Date: _____



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

ATTACHMENT 1 - To be completed by the Physician

The patient's disability requires the following modifications:

	<i>Identify ability level: Modified ("M") or Unable ("U")</i>	<i>What is the manifestation of the disability that is restricting the employee from completing the task?</i>	<i>Maximum duration (amount of time) this task can be performed in a single interval?</i>	<i>Number of Intervals (times this task can be performed in seven hours?)</i>	<i>Max weight. (applicable sections)</i>	<i>Identify the restriction is: Permanent ("P") or Temporary ("T") Note: Specify the # of days, weeks, months the restriction applies</i>
<i>Sitting</i>						
<i>Standing</i>						
<i>Walking</i>						
<i>Lifting</i>						
<i>Carrying</i>						
<i>Pushing</i>						
<i>Pulling</i>						
<i>Stairs</i>						
<i>Climbing</i>						
<i>Crouching</i>						
<i>Crawling</i>						
<i>Kneeling</i>						
<i>Twisting</i>						
<i>Bending</i>						
<i>Gripping</i>						
<i>Reaching</i>						
<i>Dexterity</i>						
<i>Balance</i>						
<i>Vision</i>						
<i>Hearing</i>						
<i>Speech</i>						
<i>Other (please specify)</i>						



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

ATTACHMENT 2 - To be completed by the Physician

The patient's disability requires the following modifications:

	<i>Identify ability level: Modified ("M") or Unable ("U")</i>	<i>What is the manifestation of the disability that is restricting the employee from completing the task?</i>	<i>Identify the restriction is: Permanent ("P") Or Temporary ("T") Note: Specify the # of days, weeks, months the restriction applies</i>
Concentration			
Understand instruction			
Work on competing tasks with time pressures			
Work in fast-paced environment (i.e. frequent interruption)			
Meet deadlines			
Prioritize			
Schedule			
Co-ordinate (i.e. people, resources)			
Organize (i.e. people, projects, workspace)			
Synthesize information			
Create/Innovate (i.e. projects, curriculum)			
Attend to detail			
Adapt to change			
Network/Socialize			
Maintain a professional demeanour/appearance			
Act with regard for others (i.e. empathize)			
Work alone			
Work in teams			
Receive complaints			
Monitor own behaviour/ emotional reactions			
Collaborate			
Emergency response (i.e. fire, suspicious person)			
Be responsible for and care for others daily and in emergencies			
Spatial cognition (i.e. mental relations, mental visualization, mental orientation)			
Visuospatial thinking (i.e. pattern matching 2D or 3D, rotations and manipulating 2D/3D info)			
Memory (i.e. retention, recall)			
Reasoning (i.e. abstract, logical)			
Other			