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. This patient is/was unfit to work from(first day of sick leave): ________________________
   Indicate Date Sick Leave started
3. Please list the dates of visits related to the current medical condition:
   ____
   ____
4. What is the general nature of the medical condition?
   ____
   ____
   ____
5. Has this patient been referred to a medical specialist? Yes ________ No_______
6. Is the patient receiving treatment? Yes ________ No_______
7. Is the patient compliant with treatment? Yes ________ No_______
8. 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: ________________________

Billing Information: **The Employee (patient) is responsible for any fee related to the review and/or completion of this form.**

If the patient's expected date of return to work is known, please complete this page.

 Revised: Sept. 1, 2015

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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)?

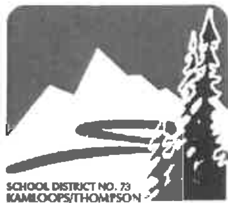
   ____
   ____
   ____

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: ___________________________

Revised: March 11, 2015



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ATTACHMENT 1 - To be completed by the Physician

The patient's disability requires the following modifications:

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

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ATTACHMENT 2 - To be completed by the Physician

The patient's disability requires the following modifications:

	Identify ability level: *Modified ("M") or Unable ("U")*	*What is the manifestation of the disability that is restricting the employee from completing the task?*	*Identify the restriction is:* *Permanent ("P") Or Temporary ("T") Note: Specify the # of days, weeks, months the restriction applies*
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			