



**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.**



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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?

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

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

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

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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: \_\_\_\_\_



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**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>						



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**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>
<i>Concentration</i>			
<i>Understand instruction</i>			
<i>Work on competing tasks with time pressures</i>			
<i>Work in fast-paced environment (i.e. frequent interruption)</i>			
<i>Meet deadlines</i>			
<i>Prioritize</i>			
<i>Schedule</i>			
<i>Co-ordinate (i.e. people, resources)</i>			
<i>Organize (i.e. people, projects, workspace)</i>			
<i>Synthesize information</i>			
<i>Create/Innovate (i.e. projects, curriculum)</i>			
<i>Attend to detail</i>			
<i>Adapt to change</i>			
<i>Network/Socialize</i>			
<i>Maintain a professional demeanour/appearance</i>			
<i>Act with regard for others (i.e. empathize)</i>			
<i>Work alone</i>			
<i>Work in teams</i>			
<i>Receive complaints</i>			
<i>Monitor own behaviour/ emotional reactions</i>			
<i>Collaborate</i>			
<i>Emergency response (i.e. fire, suspicious person)</i>			
<i>Be responsible for and care for others daily and in emergencies</i>			
<i>Spatial cognition (i.e. mental relations, mental visualization, mental orientation)</i>			
<i>Visuospatial thinking (i.e. pattern matching 2D or 3D, rotations and manipulating 2D/3D info)</i>			
<i>Memory (i.e. retention, recall)</i>			
<i>Reasoning (i.e. abstract, logical)</i>			
<i>Other</i>			