Human Resources

CONFIDENTIAL
SCHOOL DISTRICT NO. 71 (COMOX VALLEY)
607 Cumberland Road, Courtenay, B.C. V9N 7G5
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Comox Valley Schools
A Community of Learners
INNOVATIVE • INQUISITIVE • INCLUSIVE

Medical Certificate for Ability to Work with Limitations

Employee's Authorization for Release of Information and/or Request for Workplace Medical Accommodation

I,_____, hereby authorize my physician to complete this Physician's Statement and to release this Medical Certificate to my Employer.

I am requesting adaptive equipment from my Employer as a Workplace Medical Accommodation. ☐ Yes ☐ No

I provide authorization to release this information to WorkSafe BC (if applicable). ☐ Yes ☐ No

Employee's Signature_____ Date _____

Section A - Physician's Statement

1. I saw_____ on _____
   (Patient's Name) (Date)
2. I am satisfied that for bona fide medical reasons this patient is medically able to work **in a limited capacity** effective

   _____
   (Date)
3. The reason for the limited functional capabilities is due to:
   - ☐ Physical Condition
   - ☐ Other
4. This patient is medically capable of working **in a limited capacity as indicated on page 2**:
   - ☐ Full assignment
   - ☐ Part time assignment consisting of: # of Hrs/Day_____ # of Days/Wk_____ Approximate # of Weeks _____

   For gradual return to work, please provide details here:
5. My opinion is based on the factors indicated below:
   - ☐ Information provided by the patient
   - ☐ My examination of the patient and my assessment of the findings and health information.
6. Has this person been prescribed or recommended a course of treatment for the medical condition rendering him/her able to work **in a limited capacity**? ☐ Yes ☐ No

   If a course of treatment has been prescribed or recommended, has this person followed the course of treatment?

   ☐ Yes ☐ No
7. As a result of this patient's condition or limited functional capabilities, could this person pose a health and/or safety risk to others at work? ☐ Yes ☐ No
8. Has this person been referred to a medical specialist? ☐ Yes ☐ No
9. Date of next appointment is (indicate n/a if not applicable) _____
   (Date)
10. I estimate that this patient may return to work without limited functional capabilities on_____(indicate "unknown" if applicable)
    (Date)

The information in this report is considered confidential. Any charge for completion of this form is the responsibility of the employee.

What the employee <u>can do</u> on a limited basis.

Physical Capabilities:	**Not Applicable**	**<10% of the day**	**10-40% of the day**	**40-70% of the day**	**Additional Information (if applicable):**
Sitting	☐	☐	☐	☐	
Standing	☐	☐	☐	☐	
Walking	☐	☐	☐	☐	
Climbing Stairs	☐	☐	☐	☐	
Climbing Ladders	☐	☐	☐	☐	
Climbing Scaffolding	☐	☐	☐	☐	
Crouching	☐	☐	☐	☐	
Crawling	☐	☐	☐	☐	
Kneeling	☐	☐	☐	☐	
Bending / Twisting / Turning	☐	☐	☐	☐	
Repetitive Activity	☐	☐	☐	☐	
Sustained Postures	☐	☐	☐	☐	
Gripping	☐	☐	☐	☐	
Reaching	☐	☐	☐	☐	
Fine Dexterity	☐	☐	☐	☐	
Vision / Hearing / Speech	☐	☐	☐	☐	
Balance	☐	☐	☐	☐	
Lifting/Carrying	☐	☐	☐	☐	
Pushing/Pulling	☐	☐	☐	☐	
Manual Handling Capabilities:	**< 10 lbs**	**10-30 lbs**	**30-50 lbs**	**50+ lbs**	**Additional Information (if applicable):**
Lifting/Carrying	☐	☐	☐	☐	
Pushing/Pulling	☐	☐	☐	☐	

Cognitive Capabilities:	**Not Applicable**	**If applicable, please provide additional Information:**
Thinking/Reasoning/Decision Making	☐	
Concentration/Memory/Alertness	☐	

Environmental:	**Not Applicable**	**<10% of the day**	**10-40% of the day**	**40-70% of the day**	**Additional Information (if applicable):**
Exposure to Heat/Cold	☐	☐	☐	☐	
Exposure to Dust/Fumes/Odors	☐	☐	☐	☐	
Exposure to Chemicals	☐	☐	☐	☐	
Food Handling	☐	☐	☐	☐	

Other:	**Not Applicable**	**<10% of the day**	**10-40% of the day**	**40-70% of the day**	**Additional Information (if applicable):**
Operating Vehicle/Equipment	☐	☐	☐	☐	
Working in Confined Spaces	☐	☐	☐	☐	
Working at Heights	☐	☐	☐	☐	

Any Medical Restrictions:		Ongoing ☐	Estimated end date:	
		Ongoing ☐	Estimated end date:	
		Ongoing ☐	Estimated end date:	

Name of Attending Physician (please print): _____

Address: _____

Postal Code: _____ Phone: _____

Signature: _____ Date: _____

OFFICE STAMP REQUIRED

Employee and Family Assistance Program (1-800-663-1142) is available to all employees.

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