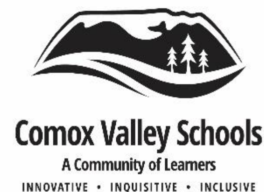
CONFIDENTIAL

SCHOOL DISTRICT NO. 71 (COMOX VALLEY)
607 Cumberland Road, Courtenay, B.C. V9N 7G5
Tel: (250) 334-5500 Email: HR@sd71.bc.ca



Certificate for Full Medical Leave of One Month or More

Employee's Authorization for Release of Information

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

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

Employee's Signature ______________________________ Date ____________________

Physician's Statement

1. I saw ______________________________ on ____________________
   (Patient's Name) (Date)
2. I am satisfied that, for bona fide medical reasons, this patient is not able to work and required an extended medical leave starting on ____________________.
   (Date)
3. The reason for the medical leave is due to:

   ☐ Physical Condition ______________________________

   ☐ Other (please specify) ______________________________
4. 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.
5. Has this person been prescribed or recommended a course of treatment for the medical condition rendering him/her unable to work?

   ☐ Yes ☐ No
6. If a course of treatment has been prescribed or recommended, has this person followed the course of treatment?

   ☐ Yes ☐ No
7. Has this person been referred to a medical specialist? ☐ Yes ☐ No
8. Date of next appointment is (indicate n/a if not applicable) ____________________
   (Date)
9. I estimate that this patient may return to work with no limitations on ____________________
   (Date)

**** Please note that our Employee and Family Assistance Program (1-800-663-1142) is available to all employees****

Name of Attending Physician (please print): ______________________________

Address: ______________________________

Postal Code: ____________________ Phone: ____________________

Signature: ____________________ Date: ____________________

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