CONFIDENTIAL
SCHOOL DISTRICT NO. 71 (COMOX VALLEY)
607 Cumberland Road, Courtenay, B.C. V9N 7G5
Tel: (250) 334-5500 Fax: (250) 338-4961

Medical Certificate for Ability to Work with Limitations

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

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

My position is ____.

I am requesting adaptive equipment from my Employer as a Workplace Accommodation ☐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 **with functional limitations** effective

   ____
   (Date)
3. The reason for the functional limitations is due to:

   ☐ Physical Condition ☐ Other
4. This patient is medically capable of working **with functional limitations 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 in Section B on page 2**)
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 **with functional limitations**? ☐ 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 functional limitations, 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 functional limitations on _____________________________ (indicate "unknown" if applicable)
    (Date)

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

Specific Functional limitations and/or restrictions

Limitation: This patient is able to perform the activity in a reduced capacity. For example, the patient is not able to perform the job with the usual speed, strength or number of repetitions, or for the usual duration.

Restriction: This patient is advised not to perform this activity in any capacity.

Physical	**Limitation**	**Restriction**	**Mental**	**Limitation**	**Restriction**
Sitting	☐	☐	Thinking / Reasoning	☐	☐
Standing	☐	☐	Concentration	☐	☐
Walking	☐	☐	Memory	☐	☐
Lifting.	☐	☐	Critical decision-making	☐	☐
Carrying	☐	☐	Alertness	☐	☐
Pushing / Pulling	☐	☐	Other *(specify in section B)*	☐	☐
Climbing stairs	☐	☐			
Climbing ladders	☐	☐	**Environmental**		
Climbing scaffolding	☐	☐	Exposure to heat / cold	☐	☐
Crouching	☐	☐	Exposure to dust / fumes / odors . . .	☐	☐
Crawling	☐	☐	Exposure to chemicals	☐	☐
Kneeling	☐	☐	Food handling	☐	☐
Bending / Twisting / Turning.	☐	☐	Other *(specify in section B)*.	☐	☐
Repetitive activity	☐	☐			
Sustained postures	☐	☐	**Other**		
Gripping	☐	☐	Working in confined spaces	☐	☐
Reaching	☐	☐	Operating vehicle	☐	☐
Fine dexterity	☐	☐	Operating equipment.	☐	☐
Balance.	☐	☐	Working at heights	☐	☐
Vision / Hearing / Speech.	☐	☐	Other *(specify in section B)*.	☐	☐
Other *(specify in section B*	☐	☐			

Section B - Details

Provide necessary information about any functional limitations/restrictions you have identified so that workplace accommodation can be considered.

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****Please note that our Employee and Family Assistance Program (1-866-644-0326) is available to all employees.**

Name of Attending Physician (please print)

____

Address ____

Postal Code______________________Phone___________________________

Signature ____

Date____

OFFICE STAMP

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