Medical Fitness for Work Certificate

Human Resources

Patient Authorization
This section must be completed and signed by patient to authorize release of medical information

Name (last Name, Given name)	Employee Number	Last day of Work

I authorize my physician to provide NAIT Health Services with the health information asked for on this form for the purpose stated below.

Signature	Date

Please mail of fax to: NAIT Health Services
11762-106 Street
Edmonton, Alberta T5G 2R1
Ph: (780) 471-8733 Fax: (780) 471-7548

General Information
The following sections must be completed by a medical physician

First date unable to work because of medical condition		
Date of hospital in-patient admission (if applicable)	Date of Surgery (if applicable)	Date of discharge (if applicable)
Expected return to work date		

Prognosis:

☐ Fit for full regular duties ☐ Fit for modified duties

☐ Not fit at this time

Is the patient compliant with treatment recommendations? ☐ Yes ☐ No

Work Restrictions

Details are required to identify accommodation opportunities for your patient

Estimated Duration of Restrictions:

_____ days ☐ 2-4 weeks ☐ 4-6 weeks ☐ 6-8 weeks ☐ 8-10 weeks

☐ more than 2 weeks ☐ Temporary ☐ Permanent

Please complete page 2 of this form

Next Follow up date

Physician Information:

Name of Attending Physician (please print)	Specialty	Phone Number	Fax Number

Address	Signature	Date

NAIT will pay up to $40.00 for full completion of this form. Forward your invoice to NAIT Health Services. Incomplete information may impact both your patient's eligibility for benefits while absent from work and payment of your invoice.

NAIT, as an employer, requires medical certification of illness or disability in order to maintain an active relationship with our employee and to facilitate an early return to work. When appropriate, NAIT will also consider providing workplace accommodations to injured or ill workers. The personal information collected on this form if for the purpose of the development of return to work plans and determining eligibility for disability benefits. It is collected under the authority of Post Secondary Act and Freedom of Information and Protection of Privacy Act. If you have any questions about the collection of this information, please contact Occupational Health and Safety (780) 471-8733.

Specific Functional Restrictions and/or Limitations

Human Resources

To be completed by Attending Physician:

Patients Name: _____

Check only those items that apply in Section A. Provide details in Section B.

Restrictions: Patient advised not to perform this activity in any capacity.
Limitations: Patients able to perform the activity in a reduced capacity. **All limitations must be quantified in Section B below.** e.g. Continuous standing limited to 2 hours

Section A	**Restriction**	**Limitation**
Physical		
Sitting	☐	☐
Standing	☐	☐
Walking	☐	☐
Lifting	☐	☐
Carrying	☐	☐
Pushing/Pulling	☐	☐
Climbing Stairs	☐	☐
Climbing Scaffolding	☐	☐
Crouching	☐	☐
Crawling	☐	☐
Kneeling	☐	☐
Bending/twisting/turning	☐	☐
Repetitive activity	☐	☐
Sustained postures	☐	☐
Gripping	☐	☐
Reaching	☐	☐
Fine Dexterity	☐	☐
Balance	☐	☐
Vision/hearing/speech	☐	☐
Other (specify in Section B)	☐	☐

	Restriction	**Limitation**
Mental		
Thinking/reasoning	☐	☐
Concentration	☐	☐
Memory	☐	☐
Critical decision making	☐	☐
Alertness	☐	☐
Other (specify in Section B)	☐	☐
Environmental		
Exposure to heat/cold	☐	☐
Exposure to dust/fumes/odours	☐	☐
Exposure to chemicals	☐	☐
Food handling	☐	☐
Other (specify in Section B)	☐	☐
Other		
Shift/Attendance duration	☐	☐
Consecutive shift duration	☐	☐
Shift work	☐	☐
Overtime	☐	☐
Operating a vehicle	☐	☐
Working at heights	☐	☐
Other (specify in Section B)	☐	☐

Does the patient require medical aids? (eg splint, brace,scooter, or personal protective equipment(eg gloves/mask)

☐ Yes ☐ No (specify in Section B) Text Field

Section B Please provide quantitative details regarding limitations. NAIT will use this information to identify opportunities to return your patient to work as soon as possible.
e.g. continuous standing limited to 2 hours

I have provided this form to the patient named above: _____ Physician Signature _____ mm/dd/yyyy