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 requires 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 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: _____

OFFICE STAMP REQUIRED

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

19/04/16