



COMOX VALLEY
SCHOOL DISTRICT

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

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.

I am requesting adaptive equipment from my Employer as a Workplace 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 can do 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing Ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climbing Scaffolding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bending / Twisting / Turning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Repetitive Activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sustained Postures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gripping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fine Dexterity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vision / Hearing / Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lifting/Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Manual Handling Capabilities:	< 10 lbs	10-30 lbs	30-50 lbs	50+ lbs	Additional Information (if applicable):
Lifting/Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pushing/Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Cognitive Capabilities:	Not Applicable	If applicable, please provide additional information:
Thinking/Reasoning/Decision Making	<input type="checkbox"/>	
Concentration/Memory/Alertness	<input type="checkbox"/>	

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exposure to Dust/Fumes/Odors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exposure to Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Food Handling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Other:	Not Applicable	<10% of the day	10-40% of the day	40-70% of the day	Additional Information (if applicable):
Operating Vehicle/Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Working in Confined Spaces	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Working at Heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Any Medical Restrictions:		Ongoing <input type="checkbox"/>	Estimated end date:
		Ongoing <input type="checkbox"/>	Estimated end date:
		Ongoing <input type="checkbox"/>	Estimated end date:

<p>Name of Attending Physician (please print): _____</p> <p>Address: _____</p> <p>Postal Code: _____ Phone: _____</p> <p>Signature: _____ Date: _____</p>	<p>OFFICE STAMP REQUIRED</p>
<p>Employee and Family Assistance Program (1-800-663-1142) is available to all employees.</p>	

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