**CONFIDENTIAL**
**SCHOOL DISTRICT NO. 71 (COMOX VALLEY)**
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Human Resources

Comox Valley Schools
A Community of Learners
INNOVATIVE • INQUISITIVE • INCLUSIVE

# 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 **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.

_____

_____

_____

_____

****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_____

**OFFICE STAMP**





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