ABBOTSFORD SCHOOL DISTRICT
HUMAN RESOURCES

Bring your best

Request for Medical Information

Employee Name: _____

First Name Last Name Position

Dear Health Care Provider:

The Abbotsford School District is committed to assisting employees that have experienced an illness or injury that is preventing them from attending work. Your patient has been asked to provide medical information to help us support them to achieve a safe, sustained and timely return to work. *The information in this report is considered confidential.*

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 understand that my employer is entitled to certain medical information and that my Physician is authorized to release this medical information under the Medical Certificates Guidelines (M-2) in the Policy Manual of the College of Physicians and Surgeons of British Columbia.

Employee's Signature: _____ **Date:** _____

SECTION A: PHYSICIAN'S STATEMENT

Following examination on _____ (Date) the above mentioned person is:

☐ **Medically fit to return to work without limitation on:** _____

Note: If employee is medically fit to return to work without limitation, no further information is required. Otherwise complete applicable information in gray below

☐ **Unfit to perform any duties from** _____ (Date) **to** _____ (Date) **(complete section B on page 2)**

☐ **Fit to return to work on** _____ (Date) **with the following limitations and/or schedule (section C on page 2):**

Activity	*Limitation Details*	**Activity**	*Limitation Details*
☐ Lifting/Carrying		☐ Pushing/Pulling	
☐ Twisting/Turning Motion		☐ Kneeling/Squatting/Crawling	
☐ Climbing Stairs/Ladders		☐ Reaching Above/Below Shoulder	
☐ Bending/Stooping		☐ Visual/Sensory Attention	
☐ Standing/Walking		☐ Mental Concentration	
☐ Gripping		☐ Other:	

Limitations/Restrictions will be in effect until: _____ (Date)

2790 Tims Street
Abbotsford BC V2T 4M7
Tel 604.859.4891
Fax 604.859.6187
hr.sd34.bc.ca

SECTION B: MEDICAL INFORMATION & TREATMENT PLAN

The medical leave is requested due to: _____

The reasons preventing this person from working are: _____

_____

Last examination date: _____ Next scheduled appointment: _____

Estimated date of return: _____

Check box if the absence is related to a: ☐ WCB Claim ☐ ICBC Claim

Has your patient been referred to a specialist? ☐ Yes ☐ No

If no, why not? _____

If yes, date of appointment: _____

Does this patient have a prescribed treatment plan? ☐ Yes ☐ No

If no, why not? _____

If yes, is the treatment plan being followed?

☐ Yes ☐ No

If no, why not? _____

SECTION C: GRADUATED RTW SCHEDULE

Please advise appropriate return-to-work schedule (e.g. - Mon/Wed/Fri – 4 hours per day)

Week #	GRTW Schedule (Hours/Days)	Week #	GRTW Schedule (Hours/Days)
1		5	
2		6	
3		7	
4		8	

HEALTH CARE PROVIDER INFORMATION

Name _____ Date _____

Address _____ Phone # _____

Signature _____

Fax completed form to: ***604-859-6187*** *or email to:*

Support Staff	*support.benefits@abbyschools.ca*
Teachers	*teacher.benefits@abbyschools.ca*
Worksafe Claims	*mysafety@abbyschools.ca*

*****The District will reimburse employees up to $37.50 upon receipt of invoice paid*****