Medical Certificate
Request for Medical Leave

To the Physician:

_____ has been asked to provide a Medical Certificate explaining the reasons for the need for medical leave _____ to _____ of _____FTE.

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 authorised 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_____

Physician's Statement

Confirmation of Reasons for a Medical Leave

1. Following examination, I certify that the above mentioned person requires a medical leave due to:

   _____
   _____
   _____

2. This illness will prevent this person from working because:

   _____
   _____
   _____
   _____

3. Course of Treatment:

   a. Has this person been prescribed a course of treatment for the medical condition rendering him/her unable to work his/her full assignment?

   _____
   _____
   _____
   _____

   b. If no course of treatment has been prescribed, has a course of treatment been recommended for this person to follow related to the medical condition rendering him/her unable to work his/her assignment?

   _____
   _____
   _____
   _____

   c. If a course of treatment has been prescribed or recommended, has this person followed the prescribed or recommended course of treatment?

   _____
   _____
   _____
   _____

   d. Has this person been referred to a medical specialist?

   Yes _____ No _____

4. He/she was seen by me regarding this illness/injury on:

   _____.

5. What medical follow-ups, if any, are occurring related to this illness/injury?

   _____
   _____
   _____

6. I estimate that this person will be able to return to their full teaching assignment on _____.

7. When this employee returns to work I anticipate the following restrictions (please include duty restrictions, maximum hours per day, and estimated length of gradual return to work):

_____

_____

_____

8. For informational purposes, this is to make you aware of the availability for employees of the Employee and Family Assistance Program. (EFAP).

Name of Attending Physician (please print)_____

Medical Speciality (please print) _____

Name of Clinic (if applicable) _____

Address _____

_____

Postal Code_____

Phone_____ Date_____

Signature _____

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