School District 8
Kootenay Lake

CONFIDENTIAL

District Medical Certificate

Employee No: _________________ **Position:** _________________ **Location:**_________________

What type of medical leave are you requesting?

- ☐ Full Medical Leave
- ☐ Partial Medical Leave

  I am able to work ____________% of my assignment

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. The guidelines of the College of Physicians and Surgeons are applicable.

Employee's Signature_______________________________Date________________________________

Physician's Statement

1. Following examination on ____________________, I certify that the above mentioned person requires a medical leave due to:
   (Please indicate the general nature of the condition(s); diagnosis is not required)

   ____

   ____

2. This medical condition(s) 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?

   ____

   ____

School District 8 Kootenay Lake

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

____

____

5. I estimate that this person will be able to return to their full assignment on

____

6. 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):

____

____

____

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) ____

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

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