

APPENDIX C - Medical Certificate

PART 1

The Board may request this medical confirmation in accordance with Article C6.1 h)

Part 2 of this form is to provide the Employer with information to assess whether the employee is able to perform the essential duties of their position and to understand restrictions and/or limitations to assess workplace accommodation if necessary.

Part 2 need only be completed for a return to work that requires an accommodation

<p>I, _____</p> <p>hereby authorize my Health Care Professional(s)</p> <p>_____</p> <p>to disclose medical information to my employer,</p> <p>_____</p> <p>In order to determine my ability to fulfill my duties as a</p> <p>_____</p> <p>from a medical standpoint, and whether my medical situation is such that it can support my sustained return to work in the foreseeable future. To this end, I specifically authorize my Health Care Professional(s) to respond to those questions from my employer set out in the medical certificate dated</p> <p>_____ dd _____ mm _____ yyyy</p> <p>for my absence starting on the</p> <p>_____ dd _____ mm _____ yyyy</p> <p>Signature _____ Date _____</p> <p>Employee ID: _____</p>	<p>Dear Health Care Professional,</p> <p>please be advised that the Employer has an accommodation and return to work program. The parties acknowledge that the employer has an obligation to provide reasonable accommodation to the point of undue hardship, and that the employee has an obligation to cooperate with reasonable accommodation measures. Consistent with this understanding, and with the objective of returning employees to active employment as soon as possible, we would ask the medical professional to provide as full and detailed information as possible.</p> <p><u>Please return the completed form to the attention of:</u></p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>Employee Address: _____</p>	<p>Telephone No: _____</p> <p>Work Location: _____</p>

Health Care Professional: The following information should be completed by the Health Care Professional			
First Day of Absence:			
General Nature of Illness* <i>(please do not include diagnosis):</i>			
Date of Assessment: dd mm yyyy	No limitations and/or restrictions <input type="checkbox"/>		
Return to work date: dd mm yyyy			
For limitations and restrictions, please complete Part 2.			
Health Care Professional, please complete the confirmation and attestation in Part 3			
PART 2 – Physical and/or Cognitive Abilities			
Health Care Professional to complete. Please outline your patient's abilities and/or restrictions based on your objective medical findings. <i>(please complete all that is applicable)</i>			
PHYSICAL (if applicable)			
Walking: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 100 metres <input type="checkbox"/> 100 - 200 metres <input type="checkbox"/> Other <i>(specify)</i> :	Standing: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15 - 30 minutes <input type="checkbox"/> Other <i>(specify)</i> :	Sitting: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 30 minutes <input type="checkbox"/> 30 minutes - 1 hour <input type="checkbox"/> Other <i>(specify)</i> :	Lifting from floor to waist: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other <i>(specify)</i> :

Lifting from Waist to Shoulder: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (<i>specify</i>):	Stair Climbing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 steps <input type="checkbox"/> 6 - 12 steps <input type="checkbox"/> Other (<i>specify</i>):	<input type="checkbox"/> Use of hand(s): Left Hand <input type="checkbox"/> Gripping <input type="checkbox"/> Pinching <input type="checkbox"/> Other (<i>specify</i>): Right Hand <input type="checkbox"/> Gripping <input type="checkbox"/> Pinching <input type="checkbox"/> Other (<i>specify</i>):		
<input type="checkbox"/> Bending/twisting repetitive movement of (<i>please specify</i>):	<input type="checkbox"/> Work at or above shoulder activity:	<input type="checkbox"/> Chemical exposure to:	Travel to Work: Ability to use public transit to: <hr/> Ability to drive car	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
COGNITIVE (if applicable)				
Attention and Concentration: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Following Directions: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Decision-Making/Supervision: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Multi-Tasking: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	
Ability to Organize: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Memory: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Social Interaction: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Communication: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	

Please identify the assessment tool(s) used to determine the above abilities (Examples: Lifting tests, grip strength tests, Anxiety Inventories, Self-Reporting, etc).

Additional comments on Limitations (not able to do) and/or Restrictions (should/must not do) for all medical conditions:

Health Care Professional: The following information should be completed by the Health Care Professional

<p>From the date of this assessment, the above will apply for approximately:</p> <p><input type="checkbox"/> 1-2 days <input type="checkbox"/> 3-7 days <input type="checkbox"/> 8-14 days</p> <p><input type="checkbox"/> 15 + days <input type="checkbox"/> Permanent</p>	<p>Have you discussed return to work with your patient?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Recommendations for work hours and start date (if applicable):</p> <p><input type="checkbox"/> Regular full time hours <input type="checkbox"/> Modified hours</p> <p><input type="checkbox"/> Graduated hours</p>	<p>Start Date: dd mm yyyy</p>
<p>Is the patient on an active treatment plan?: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has a referral to another Health Care Professional been made?</p> <p><input type="checkbox"/> Yes (optional - please specify): _____ <input type="checkbox"/> No</p> <p>If a referral has been made, will you continue to be the patient's primary Health Care Provider?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	

Please check one:		
<input type="checkbox"/>	Patient is capable of returning to work with no restrictions.	
<input type="checkbox"/>	Patient is capable of returning to work with restrictions. (Complete Part 2)	
<input type="checkbox"/>	I have reviewed Part 2 above and have determined that the Patient is totally disabled and is unable to return to work at this time.	
Recommended date of next appointment to review Abilities and/or Restrictions:	dd	mm yyyy
PART 3 – Confirmation and Attestation		
Health Care Professional: The following information should be completed by the Health Care Professional		
I confirm all of the information provided in this attestation is accurate and complete:		<input type="checkbox"/>
Completing Health Care Professional Name: (Please Print)	_____	
Date:	_____	
Telephone Number:	_____	
Signature:	_____	

* "General Nature of Illness" (or injury) suggests a general statement of a person's illness or injury in plain language without any technical medical details, including diagnosis. Although revealing the nature of an illness may suggest the diagnosis, it will not necessarily do so. "Nature of illness" and "diagnosis" are not congruent terms. For example, a statement that a person has a cardiac or abdominal condition or that s/he has undergone surgery in that respect reveals the essence of the situation without revealing a diagnosis.

Additional or follow up information may be requested as appropriate.