School District #49 (Central Coast)
1961 Highway 20, PO Bag 130, Hagensborg, BC, V0T 1H0
Phone: (250) 982-2691 Fax: (250) 982-2319

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?

_____

_____

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