Occupational Medical Certificate

I authorize the physician, whom I have attended, to release to the Cowichan Valley School District #79 the information below for use in assessing capacity for work.

Employee's Name: *(print)* Signature:

1. Physician's Statement:

Following examination on ______________, I certify that the above named person is:

- ☐ Not physically and psychologically fit for any work
- ☐ Physically and psychologically fit in some capacity for work with restrictions/limitations

2. Treatment Recommendations:

Are there evidenced-based treatments considered to improve the medical condition for which this individual is diagnosed, or medical investigations that would assist in assessing or managing their condition?

☐ YES ☐ NO

If a course of treatment has been prescribed/recommended, the individual is ☐ is not ☐ following the prescribed/recommended treatment.

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What plans are in place for monitoring the individual's condition?

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Are there any non-medical barriers to a functional recovery? ☐ YES ☐ NO

3. Prognosis:

Please outline the prognosis for functional capacity of the individual's condition, including anticipated date of their initial return.

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Please outline the anticipated prognosis for duration of any restrictions/limitations: when could the individual be expected to return to their full duties?

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4. Physical limitations of worker:

Please outline any current physical restrictions or limitations of this individual:

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5. Psychological/Cognitive limitations of worker:

Please outline any current psychological/cognitive restrictions or limitations of this individual:

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6. Additional Comments:

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School District 79 supports its employees' health and wellness and sees value in having employees attached to the workplace. Where job demands permit, options such as a graduated return to work, modified duties or modified hours within the above noted restrictions/limitations will be considered.

Physician: *(Print)* ______________________________ **Signature:** ______________________________

Physician's Phone Number: ____________________ **Physician's Address:** ______________________

Date: ______________________________ ______________________________________