Algonquin & Lakeshore
Catholic District School Board

Subject: Medical Certificate for completion

I am forwarding the attached Medical Certificate for completion.

Please scan and email the completed document to abilityandwellness@alcdsb.on.ca or fax it to our confidential line at 613-354-4772.

Thank you,

Ability and Wellness
Algonquin and Lakeshore Catholic District School Board
151 Dairy Avenue, Napanee, ON K7R 4B2
T: 613-354-6257 ext. 479
www.alcdsb.on.ca | abilityandwellness@alcdsb.on.ca

Algonquin & Lakeshore
Catholic District School Board

DISCIPLESHIP | SCHOLARSHIP | STEWARDSHIP

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

I, _____

hereby authorize my Health Care Professional(s)

_____

to disclose medical information to my employer,

_____

In order to determine my ability to fulfill my duties as a

_____

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

dd **mm** **yyyy**

for my absence starting on the

dd **mm** **yyyy**

Signature Date

Dear Health Care Professional,

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.

Please return the completed form to the attention of:

Ability and Wellness, Human Resources
Fax: 613-354-4772
Email: AbilityandWellness@alcdsb.on.ca

Employee ID:

Telephone No:

Employee

Address:

Work Location:

Employee/Patient Name (please print): _____

Health Care Professional: The following information should be completed by the Health Care Professional	
First Day of Absence:	
General Nature of Illness* ***(please do not include diagnosis)**:*	
Date of Assessment: **dd mm yyyy**	No limitations and/or restrictions ☐ 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. (please complete all that is applicable)

PHYSICAL (if applicable)

Walking:	**Standing:**	**Sitting:**	**Lifting from floor to waist:**
☐ Full Abilities ☐ Up to 100 metres ☐ 100 - 200 metres ☐ Other *(specify):*	☐ Full Abilities ☐ Up to 15 minutes ☐ 15-30 minutes ☐ Other (specify):	☐ Full Abilities ☐ Up to30 minutes ☐ 30 minutes - 1 hour ☐ Other *(specify):*	☐ Full Abilities ☐ Up to 5 kilograms ☐ 5 - 10 kilograms ☐ Other *(specify):*

Employee/Patient Name (please print): _____

Lifting from Waist to Shoulder: ☐ Full abilities ☐ Up to 5 kilograms ☐ 5 – 10 kilograms ☐ Other (specify):	**Stair Climbing:** ☐ Full abilities ☐ Up to 5 steps ☐ 6 – 12 steps ☐ Other (specify):	☐ **Use of hand(s):** **Left Hand** ☐ Gripping ☐ Pinching ☐ Other *(specify):* **Right Hand** ☐ Gripping ☐ Pinching ☐ Other(specify):		
☐ **Bending/twisting** repetitive movement of *(please* specify):	☐ **Work at or above shoulder activity:**	☐ **Chemical exposure to:**	**Travel to Work:** Ability to use public transit	☐ Yes ☐ No
			Ability to drive car	☐ Yes ☐ No

COGNITIVE (if applicable)			
Attention and Concentration: ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Following Directions:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Decision-Making/Supervision:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Multi-Tasking:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:
Ability to Organize: ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Memory:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Social Interaction:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Communication:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:

Employee/Patient Name (please print): _____

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

From the date of this assessment, the above will apply for approximately:

☐ 1-2 days ☐ 3-7 days ☐ 8-14 days
☐ 15 + days ☐ Permanent

Have you discussed return to work with your patient?

☐ Yes ☐ No

Recommendations for work hours and start date (if applicable):

☐ Regular full time hours ☐ Modified hours
☐ Graduated hours

Start Date: **dd** **mm** **yyyy**

Is the patient on an active treatment plan?: ☐ Yes ☐ No

Has a referral to another Health Care Professional been made?

☐ Yes (optional- please specify):_____ ☐ No

If a referral has been made, will you continue to be the patient's primary Health Care Provider? ☐ Yes ☐ No

Please check one:

☐ Patient is capable of returning to work with no restrictions.
☐ Patient is capable of returning to work with restrictions. **(Complete Part 2)**
☐ **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

Employee/Patient Name (please print): _____

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 a Health Care Professional**
I confirm all of the Information provided in this attestation is accurate and complete: ☐
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.