CONFIDENTIAL

Christ the Teacher Catholic Schools

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Medical Certificate for Ability to Work with Limitations

Employee's Authorization for Release of Information

I will be / have been absent from work since (date) _____.

I consent to the release of the following information to my employer. The following information is required to allow my employer to assist me in returning to work or assisting in work accommodation as required.

Last Name _____ First Name _____

Employee's Signature _____ Date _____

Section A - Physician's Statement

1. Date of initial contact with the patient regarding this illness/injury: _____/_____/_____ (Day/Month/Year)
2. I am satisfied that for bona fide medical reasons this patient is medically able to work **with functional limitations** effective

   _____ .
3. The reason for the functional limitation is due to: ☐ Physical Condition ☐ Other
4. This patient is medically capable of working **with functional limitations as indicated on page 2**:

   ☐ Full assignment

   ☐ Part-time assignment consisting of: # of Hours./Day _____ # Days/Week _____ Approximate # of Weeks _____

   (For gradual return to work, please provide details in Section B on page 2)
5. My opinion is based on the factors indicated below:

   ☐ Information provided by the patient

   ☐ My examination of the patient and my assessment of the findings and health information.
6. Has this person been prescribed or recommended a course of treatment for the medical condition rendering him/her able to work **with functional limitations**? ☐ Yes ☐ No

   If a course of treatment has been prescribed or recommended, has this person followed the course of treatment?

   ☐ Yes ☐ No
7. As a result of this patient's condition or functional limitations, could this person pose a health and/or safety risk to others at work?
8. Has this person been referred to a medical specialist? ☐Yes ☐ No
9. Date of the next appointment is (indicate n/a if not applicable) _____
10. I estimate that this patient may return to work without functional limitations on _____ (indicate unknown if applicable).

The information is this report is considered confidential. Any charge for completion of this form is the responsibility of the claimant.

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Specific Functional Limitations and/or Restrictions

Limitation: This patient is able to perform the activity in a reduced capacity. For example, the patient is not able to perform the job with the usual speed, strength or number of repetitions, or for the usual duration.

Restriction: This patient is advised not to perform this activity in any capacity.

	Limitation	Restriction		Limitation	Restriction
Physical	☐	☐	**Mental**		
Sitting	☐	☐	Thinking/Reasoning	☐	☐
Standing	☐	☐	Concentration	☐	☐
Walking	☐	☐	Memory	☐	☐
Lifting	☐	☐	Critical decision- making	☐	☐
Carrying	☐	☐	Alertness	☐	☐
Pushing/Pulling	☐	☐	Other (specify in section B)	☐	☐
Climbing Stairs	☐	☐			
Climbing Ladders	☐	☐	**Environmental**		
Climbing Scaffolding	☐	☐	Exposure to heat/cold	☐	☐
Crouching	☐	☐	Exposure to dust/fumes/odours	☐	☐
Crawling	☐	☐	Exposure to chemicals	☐	☐
Kneeling	☐	☐	Food handling	☐	☐
Bending/Twisting/Turning	☐	☐	Other (specify in section B)	☐	☐
Repetitive Activity	☐	☐			
Sustained Postures	☐	☐	**Other**		
Gripping	☐	☐	Working in confined spaces	☐	☐
Reaching	☐	☐	Operating vehicle	☐	☐
Fine Dexterity	☐	☐	Operating equipment	☐	☐
Balance	☐	☐	Working at heights	☐	☐
Vision/Hearing/Speech	☐	☐	Other (specify in section B)	☐	☐
Other (specify in section B)	☐	☐			

Section B – Details

Please provide necessary information regarding any functional limitations/restrictions you have identified so that workplace accommodation can be considered.

Name of Attending Physician (please print)

_____

Address _____

Postal Code _____ Phone _____

Signature _____

Date _____

OFFICE STAMP

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