Medical Certificate

Clearview Public Schools
We All Belong – We All Succeed

To the Physician:

{Name}, who is **{Occupation}** with Clearview Public Schools, has been asked to provide a medical certificate. The purpose of this form is to provide the employer with the information to confirm that an absence from work is necessary for medical reasons and to help the employer make decisions about accommodating the patient, providing disability leave, or assessing if the patient can return to work.

This form does not replace forms related to an employee's ability to work that are required by: Workers' Compensation Board, third-party insurers, or employer-funded medical benefit plans.

Consent:

I, _____ (print name) hereby authorize my physician to complete the assessment herein contained and to release it to my employer, Clearview School Division.

Employee signature:_____ Date:_____

Confirmation of Reasons for Medical Leave

1. I saw the patient on _____ (Date).

2. Is (was) your patient unable to attend or perform work due to an illness or medical reason? ☐ Yes ☐ No
   If so, since what date? _____ (Date).

3. The following are the symptoms or the functional limitations or restrictions associated with the illness or injury that are preventing the employee from completing their duties (do not provide the diagnosis):

   _____

   _____

   _____

   _____

   _____

4. What are the workplace triggers or circumstances that bring on or exacerbate any limitations or restrictions?

   _____

   _____

   _____

   _____

   _____

5. Was/is the illness/injury related to pregnancy/maternity? ☐ Yes ☐ No
   If post-delivery, the date of delivery was _____ (Date).

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6. Given the health information before me:
   - ☐ This patient may return to work with no limitations or restrictions on _____ (Date).
   - ☐ This patient needs further medical assessment before returning to work. Date of the next appointment is _____ (Date).
     If the date of return is unknown, is the absence likely to be:
     ☐ Less than 30 days ☐ 30 - 90 days ☐ Greater than 90 days
   - ☐ This patient is medically able to work with limitations and / or restrictions as of _____ (Date). **If selected, question 7 must be completed.**
     In my opinion, these restrictions or limitations are:
     - ☐ Temporary: ☐ ____ days ☐ Less than 2 weeks ☐ 2 to 4 weeks ☐ 4 to 6 weeks ☐ 6 weeks to 3 months ☐ more than 3 months
     - ☐ Permanent

7. Please provide necessary details about any restrictions or limitations. **Note: Complete only if the individual can return with limitations and/or restrictions.**

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

8. 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.

Instructions to the physician for returning medical certificate:

- Please email this form directly to Mark Siemens at msiemens@clearview.ab.ca or send by facsimile to 403-742-1388 (Attention Mark Siemens). This will be treated in confidence.
- Thank you in advance for your assistance. Please contact me at 403-742-3331 or the email above if you have any questions.
- We will pay the reasonable costs associated with you providing this information.

Physician's Information - Please sign and date below to indicate the authenticity of your responses

1. Name (printed): _____
2. Address: _____
   _____
3. Phone Number: _____
4. Signature: _____
5. Date: _____

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