



# MEDICAL CERTIFICATE

## REQUEST FOR EXTENDED or PARTIAL MEDICAL LEAVE

The information in this report is considered confidential.

Please note: Any costs incurred for completion of this form is the patient's responsibility.

<b>A. To Be Fully Completed by Employee</b>			
Employee's Surname: _____		Given Names: _____	
Work Location	Position	Start Date of Current Absence	_____ (D/M/Y)
I authorize my health care provider(s) to complete this Physician's Statement and to release this Medical Certificate to my Employer.			
Employee Signature _____		Date Signed (D/M/Y) _____	
<b>B. Physician's Statement: To Be Fully Completed by Attending Physician</b>			
Examination Date _____ (D/M/Y)	Has this individual been referred to a medical specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	I anticipate that this individual will be able to return to their full work assignment on: _____ (D/M/Y)	
Have you recommended a treatment program for your patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your patient following this treatment program? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please indicate if this claim is either of the following: <input type="checkbox"/> WorkSafe BC <input type="checkbox"/> ICBC	
I certify that the above named individual requires a medical leave due to:			
In the case of a partial leave request, are there ways to address the medical cause other than a reduced workload? If yes, please elaborate.			
This illness will prevent this employee from working because:			
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)			
What medical follow-ups, if any, are occurring related to this illness/injury?			
<i>For information purposes only: Please be aware of the availability of Employee and Family Assistance Program (EFAP)</i>			
I have discussed the above information with my patient <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician's Name	Physician's Signature	Date Signed _____ (D/M/Y)	Physician Tel. No.
Physician's Address			Physician Fax No.

**Please return this form to Gulf Islands School District:**

Attention: Linda Underwood, Director of Instruction, Human Resources (fax/email address): 250. 537.4200 / [lunderwood@sd64.bc.ca](mailto:lunderwood@sd64.bc.ca)

**September 2014**