CATHOLIC DISTRICT SCHOOL BOARD OF EASTERN ONTARIO
Human Resources Department
2755 Highway 43, Kemptville, ON K0G 1J0
1-800-443-4562 or 613-258-7757
www.cdsbeo.on.ca

This form shall be provided by the medical practitioner to the employee who will then deliver it to the Human Resources Department.

MEDICAL CERTIFICATE

Part 1 – Employee - please complete following:

Employee Name: _____

The information supplied will be used in a confidential manner and may assist in creating a return to work plan.

I hereby consent to the completion of this form by (Treating Medical Practitioner's Name):

_____

☐ Absent from Work

_____
(first day of absense)

☐ Not absent from work but requires accommodations

Signature of Employee: _____

Date (dd/mm/yyyy): _____

Part 2 – Medical Practitioner - please complete following:

1. Nature of Illness (do not provide diagnosis):

_____

*** "Nature of the illness"(or injury) suggests a general statement of a person's illness or injury in plain language without any technical medical details, including diagnosis or symptoms. 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.**

2. Is this condition the result of: (check one)

☐ Non-occupational illness/injury ☐ Occupational illness/injury

3. Is he/she receiving treatment: ☐ Yes ☐ No

4. Has or will a referral to a specialist been made? ☐ Yes ☐ No

If yes, date of referral (dd/mm/yyyy): _____

5. Have you discussed return to work with your patient? ☐ Yes ☐ Not at this time

6. Is the patient able to return to work: ☐ with accommodation ☐ without accommodation

Expected date of return (dd/mm/yyyy): _____

☐ unable to return to work at this time

7. Date of next assessment (dd/mm/yyyy): _____

Health Care Practitioner Signature: _____

Date Completed (dd/mm/yyyy): _____

Health Care Practitioner Name and Address: _____

_____

Part 3 and/or 4 need only be completed for a return to work that requires an accommodation.

Part 3 – Medical Practitioner – please complete the following:

COGNITIVE LIMITATIONS AND/OR RESTRICTIONS ☐ N/A

Please describe **cognitive** limitations and/or restrictions. Physical limitations and/or restrictions, if any, can be detailed in Part 4. These cognitive restrictions will be assessed when determining modified work either in the employee's own position or another suitable position.

Date of Assessment (dd/mm/yyyy):_____

Level of Functioning (Please circle which level applies for each task)	Level 1	Level 2	Level 3	Level 4
Supervision Required	☐ needs constant supervision	☐ needs frequent supervision	☐ needs limited supervision	☐ requires no supervision
Supervision of Others	☐ not able to supervise others	☐ can meet demands of or for occasional supervision	☐ can meet demands of or for regular supervision	☐ can meet demands of full supervision
Tolerance to Deadlines	☐ cannot deal with deadline pressures	☐ occasionally deal with deadlines	☐ can deal with deadlines that are reoccurring	☐ can deal with strict deadlines
Attention to Detail (indicate maximum time the Individual can concentrate)	☐ concentration on detail is severely limited	☐ concentrate on detail is limited	☐ can concentrate on details, needs occasional breaks of non detailed work	☐ able to concentrate intensely on detailed work
Performance of Multiple Tasks	☐ can deal with one task at a time	☐ can handle more than 1 task but requires cues as to when to do task	☐ can handle multiple tasks requires some time management assistance	☐ fully able to handle multiple tasks without difficulty
Tolerance to External Stimulus	☐ needs quiet, non distracting work environment	☐ can cope with small degree of distraction	☐ can cope with distracting stimuli for portion of day	☐ fully able to cope with multiple stimuli without negative effect
Ability to Work with Others Cooperatively	☐ tolerates working alone	☐ can tolerate others within vicinity, but needs to perform independent tasks	☐ can work with others cooperatively when required	☐ fully able to work in close cooperation with others
Confrontational Situations	☐ unable to cope with confrontational situations	☐ can cope with exposure to confrontational situations with back-up available	☐ moderate ability to cope with confrontational situations	☐ able to deal with confrontational situations with tact and control
Responsibility and Accountability	☐ errors in judgment or attention likely to occur	☐ can exercise a moderate level of responsibility with occasional need for support	☐ can accept responsibility including the responsibility for the safety of others	☐ can accept a high level of responsibility including sensitive situations

Prognosis (based on objective assessments)

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

☐ 1-2 Weeks ☐ 3-5 Weeks ☐ 6-8 Weeks ☐ 2-3 Months ☐ 4-6 Months
☐ 6+ Months ☐ Unknown

Recommendations for work hours and start date:

☐ Regular full time hours ☐ Modified hours ☐ Graduated hours

Start Date (dd/mm/yyyy): _____

Next appointment date to review Limitations and/or Restrictions (dd/mm/yyyy):_____

Part 4 - Medical Practitioner – please complete the following:

PHYSICAL LIMITATIONS AND/OR RESTRICTIONS ☐ N/A

Please describe physical limitations and/or restrictions only. Cognitive limitations and/or restrictions, if any, can be detailed in Part 3. These physical restrictions will be assessed when determining modified work either in the employee's own position or another suitable position.

Date of Assessment (dd/mm/yyyy): _____

Walking:
- ☐ Full abilities
- ☐ Up to 100 metres
- ☐ 100 - 200 metres
- ☐ Other (please specify)

_____

Standing:
- ☐ Full abilities
- ☐ Up to 15 minutes
- ☐ 15 - 30 minutes
- ☐ Other (please specify)

_____

Sitting:
- ☐ Full abilities
- ☐ Up to 30 minutes
- ☐ 30 minutes - 1 hour
- ☐ Other (please specify)

_____

Lifting from floor to waist:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

_____

Lifting from waist to Shoulder:
- ☐ Full abilities
- ☐ Up to 5 kilograms
- ☐ 5 - 10 kilograms
- ☐ Other (please specify)

_____

Stair Climbing:
- ☐ Full abilities
- ☐ Up to 5 steps
- ☐ 5 - 10 steps
- ☐ Other (please specify)

_____

☐ **Bending/twisting repetitive movement of** (please specify)**:**

_____

☐ **Work at or above shoulder activity:**

_____

Limited pushing/pulling with:
- ☐ Left Arm
- ☐ Right Arm
- ☐ Other (please specify)

_____

☐ **Limited use of hand(s):**

Left	**Right**
☐ Gripping	☐ Gripping
☐ Pinching	☐ Pinching
☐ Other	☐ Other

_____

☐ **Operating motorized Equipment**

☐ **Environmental Exposure to: (heat, cold, noise)**

☐ **Chemical exposure to:**

_____

☐ **Exposure to Vibration:**
- ☐ Whole body
- ☐ Hand/arm

Other (Please describe)**:** _____

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

☐ 1-2 Weeks ☐ 3-5 Weeks ☐ 6-8 Weeks ☐ 2-3 Months ☐ 4-6 Months
☐ 6+ Months ☐ Unknown

Recommendations for work hours and start date:

☐ Regular full time hours ☐ Modified hours ☐ Graduated hours

Start Date (dd/mm/yyyy):

_____

Next appointment date to review Limitations and/or Restrictions (dd/mm/yyyy): _____

Please provide any additional information/comments/findings/limitations (ex. Physical, Cognitive) which you feel would assist our employee in a safe and timely return to work.

_____

_____

PART 5 – Health Care Practitioner Information

Health Care Practitioner Signature: _____

Date Completed (dd/mm/yyyy): _____

Health Care Practitioner Name and Address:

_____

_____