Delta School District
Inspired Learning

C O N F I D E N T I A L

School District No. 37
Human Resources Division
4585 Harvest Drive
Delta, B.C. V4K 5B4
Phone: 604 946-4101 Fax: 604 952-5378

MEDICAL CERTIFICATE – FULL MEDICAL LEAVE

Please return marked CONFIDENTIAL to:
Shannon Hunt, District Administrator, Human Resources

To the Physician:

_____ has been asked to provide a Medical Certificate explaining the

reasons for extended medical leave from _____ **to** _____

EMPLOYEES AUTHORIZATION FOR RELEASE OF INFORMATION

I,_____, hereby authorize my physician to release the necessary information regarding my **current illness or injury** to School District No. 37 (Delta). I authorize my physician to fully respond to each of the requested statements/questions below as it relates to my request for extended medical leave consistent with the guidelines of the College of Physicians and Surgeons on medical certificates (M-2).

_____ _____
Employee Signature Date

Physician's Statement

Confirmation of Reasons for EXTENDED Medical Leave

1. Following examination, I certify that the above-mentioned person requires an extended medical leave due to:

   _____

   _____

2. This illness will prevent this person from working because:

   _____

   _____

3. **Course of Treatment:**

   a) Has this person been prescribed a course of treatment for the medical condition rendering him/her unable to work his/her assignment?

   _____

   _____

Cont'd….

b) If no course of treatment has been prescribed, has a course of treatment been recommended for this person to follow related to the medical condition rendering him/her unable to work his/her assignment?

c) If a course of treatment has been prescribed or recommended, has this person been following such prescribed or recommended course of treatment?

d) Has this person been referred to a medical specialist?

4. This illness/injury will prevent this person from working their full assignment because:

5. He/she was first seen by me regarding this illness/injury on:_____

6. What medical follow-ups, if any, are occurring related to this illness/injury?

7. I estimate that this person will be able to return to their teaching assignment on:_____

8. 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 if required):*

NAME AND STAMP OF ATTENDING PHYSCIAN	
	Date: _____ Signature:_____

The information in this report is considered confidential.

Any charge for completion of this form is the responsibility of the claimant.