



CONFIDENTIAL
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 Principal, Human Resources shunt@deltaschools.ca

To the Physician:

\_\_\_\_\_ has been asked to provide a Medical Certificate explaining the reason for their full-time
(employee name)
extended medical leave from \_\_\_\_\_, 20\_\_\_\_ to \_\_\_\_\_, 20\_\_\_\_. (or June 30th, 20\_\_\_\_).

\*\*Please Note: Patient will require a doctor's note for the following:

- alter return date
• alter FTE
• return to work after 4 weeks

EMPLOYEE'S AUTHORIZATION FOR RELEASE OF INFORMATION (to be signed by employee)

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 an extended full-time 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 full-time EXTENDED Medical Leave:

- 1. This full-time medical leave is as a result of a WorkSafe Claim? Yes / No
2. Following examination, I certify that the above-named person requires an extended full-time medical leave
due to:
3. This illness/injury will prevent this person from working in any capacity because:

**4. Course of Treatment:**

a. Has this person been prescribed or recommended a course of treatment for the medical condition rendering this person unable to work their assignment?

Yes /  No

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

Yes /  No

c. Has this person been referred to a medical specialist for this illness/injury?

Yes /  No

5. This person 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 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 PHYSICIAN**

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Phone: \_\_\_\_\_

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

**\*\*ALL absences longer than 4 weeks will require a medical return-to-work note and 5 days email notice prior to returning. Failure to provide a RTW note will result in being sent home.**

**\*\*If absence is shorter than 4 weeks, a 48-hour email notice is required.**