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 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.