



**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:

Kevin Vasconcelos, District Principal, Human Resources [kvasconcelos@deltaschools.ca](mailto:kvasconcelos@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 30<sup>th</sup>, 20\_\_\_\_)

**\*\*Please Note: Patient will require a doctor’s note to alter return date or FTE  
Return to work note required a minimum of 48 hours prior to return date.\*\***

**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? Y / N
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:  
\_\_\_\_\_  
\_\_\_\_\_

