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 – PART-TIME MEDICAL LEAVE

Please return marked CONFIDENTIAL to:
Kevin Vasconcelos, District Principal, Human Resources kvasconcelos@deltaschools.ca

To the Physician:

_____ has been asked to provide a Medical Certificate explaining the reason for their part-time extended medical leave from _____, 20____ to _____, 20_____ (or unknown).
(employee name)

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 part-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 part-time medical leave is as a result of a WorkSafe Claim? Y / N

2. Following examination, I certify that the above-named person, while medically unable to work their full assignment, is capable of working part-time on the following basis (number of days/week & portion of day):

   _____

3. This illness/injury will require this person to work a part-time teaching assignment because:

   _____

   _____

4. **Course of Treatment:**
   a. Has this person been prescribed or recommended a course of treatment giving rise to the request for a partial teaching 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 full teaching assignment on: _____

8. How can the medical condition, which is the cause of this application for working a partial teaching assignment, be addressed by alterations to this person's assignment other than a reduced teaching load?

_____

_____

_____

NAME AND STAMP OF ATTENDING PHYSICIAN

Date: _____

Signature: _____

Phone: _____

****Please Note: Patient will require a doctor's note to alter return date, FTE, or to resume full duties.****

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