Surrey Schools

CONFIDENTIAL
District Medical Certificate

Employee No: _____

Please indicate the type of medical leave you are requesting, as well as the start date and proposed end date

Full Medical Leave ☐ Partial Medical Leave ☐ % of Assignment _____

Start Date: _____ End Date: _____

Any charge for the completion of this form is the responsibility of the employee

EMPLOYEE'S AUTHORIZATION FOR RELEASE OF INFORMATION

I, (*please print name*) _____, hereby authorize my physician to complete this Physician Statement and release this Medical Certificate to my Employer. The guidelines of the College of Physicians and Surgeons are applicable.

Employee's Signature:_____ Date:_____

PHYSICIAN'S STATEMENT
Confirmation of Reasons for Medical Leave

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

2. This illness/injury will prevent this person from working (either full time or part-time) because:
   (i.e. limited standing, walking, increased pain etc.)

3. Course of Treatment:
   a) Has this person been ***prescribed*** a course of treatment for their medical condition?

      If yes, are they following treatment?

   b) If no course of treatment has been prescribed, has a course of treatment been ***recommended***?

      If yes, are they following the recommended treatment?

4. Has this person been referred to a specialist? *(i.e. surgeon; psychologist)* Yes ☐ No ☐

5. He / She was seen by me regarding this illness/injury on _____ *(Date)*

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

7. Prognosis for return to work:

   Full Return: ☐ Date: _____

   Partial Return: ☐ Date: _____ % of Assignment _____

   Restrictions and/or Limitations: _____

   _____

   _____

   Approximate end date for restrictions/limitations: _____

   Do they require a gradual return to work? If yes, please indicate details and duration:

   _____

   _____

   _____

PHYSICIAN INFORMATION

Name of Attending Physician (*please print*)_____

Address_____

Phone:_____

Date:_____

Signature:_____

Office Stamp *(if available)*

The information in this report is considered confidential. Completed forms may be reviewed by an external medical consultant who is governed by their own professional protocols concerning confidentiality

Please send completed medical certificate under confidential cover to the address below or
Confidential Fax: 604-595-6112
Or by email to: HealthServices@surreyschools.ca
For Enquiries Please Phone: 604-595-5382