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 Rod Allnutt, District Administrator Human Resources – Teaching Staff)

Employees Authorization for Release of Information

I _____hereby authorize my physician to complete this "Physician's Statement" by fully answering the inquiries and questions in "Physician's Statement" consistent with the Guidelines of the College of Physicians and Surgeons on medical certificates (M-2).

_____ _____

Employee Signature **Date**

Physician's Statement

Following examination, I certify that the above-mentioned person, while medically unable to work his/her full assignment, is capable of working part-time on the following time basis

_____

_____

I certify that the above mentioned person requires a partial medical leave due to

_____

_____

_____

Course of Treatment

(a) Has this person been prescribed a course of treatment for the medical condition giving rise to the request to teach a partial teaching assignment?

_____

_____

Cont'd. . . .

(b) If no course of treatment has been prescribed, has a course of treatment been recommended for this individual to follow:

_____

_____

(c) If a course of treatment has been prescribed or recommended, has this person been following such prescribed or recommended course of treatment?

_____

(d) Have medical follow-ups occurred or are they occurring in connection with the medical condition giving rise to a request to teach a partial teaching assignment?

_____

_____

(e) This illness/injury will prevent this person from working their full assignment because

_____

_____

(f) He/she was seen by me regarding this illness/injury on _____

(g) I estimate this person will be able to return to their full teaching assignment on

_____

(h) 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:** _____

The information in this report is considered confidential.

Any charge for completion of this form is the responsibility of the claimant.