MEDICAL CERTIFICATE
Request for Extended Medical Leave

To the Physician:

_____ has been asked to provide a Medical Certificate explaining the reasons for the need for extended medical leave from _____to _____.

Employee's authorization for release of information

I, _____ hereby authorize my physician to complete this Physician's Statement and to release this Medical Certificate to my Employer.

Employee's Signature _____ Date _____

Physician's Statement

Confirmation of Reasons for Extended Medical Leave

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

_____

_____

_____

_____

_____

_____

Le Conseil scolaire francophone de la Colombie-Britannique

100-13511 Commerce Parkway
Richmond (C.-B.) V6V 3A4

T. *1-604-214-2600 / 1-888-715-2200*
F. *604-214-9881*

info@csf.bc.ca
www.csf.bc.ca

2. This illness will prevent this person from working because:

3. Course of Treatment:

a) Has this person been prescribed a course of treatment for the medical condition rendering him/her unable to work his/her full assignment?

b) If no course of treatment has been prescribed, has a course of treatment been recommended for this person to follow related to the medical condition rendering him/her unable to work his/her assignment?

c) If a course of treatment has been prescribed or recommended, has this person followed the prescribed or recommended course of treatment?

d) Has this person been referred to a medical specialist?

Yes _____ No _____

4. He/she was seen by me regarding this illness/injury on _____

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

_____

_____

_____

_____

_____

_____

6. I estimate that this person will be able to return to their full teaching assignment on:

_____

7. 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)*:

_____

_____

_____

_____

For informational purposes, this is to make you aware of the availability for employees of the Employee and Family Assistance Program (EFAP) – 1.800.667.0993 (www.fseap.bc.ca/fr)

Name of Attending Physician (please print) _____

Telephone _____

Signature _____ Date _____

Office's stamp

The information in this report is considered CONFIDENTIAL.

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

Révisé le 2014-08-15