

**Appendix B**

This form shall be provided by the medical practitioner to the employee who will then deliver it to the Human Resources Department.

**Medical Certificate**

**Part 1 – Employee - please complete following:**

\_\_\_\_\_

(Employee Name)

The information supplied will be used in a confidential manner and may assist in creating a return to work plan.

I hereby consent to the completion of this form by:

\_\_\_\_\_

(Treating Medical Practitioner's Name)

|                          |  |
|--------------------------|--|
| <input type="checkbox"/> | Absent from Work<br>_____<br>(first date of absence) |
| <input type="checkbox"/> | Not absent from work but requires accommodations     |

\_\_\_\_\_

(Signature of Employee)

\_\_\_\_\_

(Date)

**Part 2 – Medical Practitioner – please complete the following**

1. Nature of Illness (do not provide diagnosis):

\_\_\_\_\_

**\* "Nature of the illness"(or injury) suggests a general statement of a person's illness or injury in plain language without any technical medical details, including diagnosis or symptoms. Although revealing the nature of an illness may suggest the diagnosis, it will not necessarily do so. "Nature of illness" and "diagnosis" are not congruent terms. For example, a statement that a person has a cardiac or abdominal condition or that s/he has undergone surgery in that respect reveals the essence of the situation without revealing a diagnosis.**

2. Is this condition the result of: (check one)

Non-occupational illness/injury

Occupational illness/injury

3. Is he/she receiving treatment:  Yes  No

4. Has or will a referral to a specialist been made?  Yes  No

If yes, date of referral: \_\_\_\_\_  
(dd/mm/yyyy)

5. Have you discussed return to work with your patient?  Yes  Not at this time

6. Is the patient able to return to work:  with accommodation  without accommodation

Expected date of return: \_\_\_\_\_  
(dd/mm/yyyy)

unable to return to work at this time

7. Date of next assessment: \_\_\_\_\_  
(dd/mm/yyyy)

**Part 3 and/or 4 need only be completed for a return to work that requires an accommodation.**

**Part 5 below is to be completed.**

**Part 3 – Medical Practitioner – please complete the following:****COGNITIVE LIMITATIONS AND/OR RESTRICTIONS** N/A

Please describe **cognitive** limitations and/or restrictions. Physical limitations and/or restrictions, if any, can be detailed in Part 4. These cognitive restrictions will be assessed when determining modified work either in the employee's own position or another suitable position.

**Date of Assessment:** \_\_\_\_\_  
(dd/mm/yyyy)

| Level of Functioning<br>(Please circle which level applies for each task)            | <b>LEVEL 1</b>                                  | <b>LEVEL 2</b>   | <b>LEVEL 3</b>  | <b>LEVEL 4</b>   |
|--|---|--|---|--|
| <b>Supervision Required</b>  | needs constant supervision                      | needs frequent supervision   | needs limited supervision   | requires no supervision  |
| <b>Supervision of Others</b>   | not able to supervise others                    | can meet demands of or for occasional supervision                                | can meet demands of or for regular supervision                                  | can meet demands of full supervision                                     |
| <b>Tolerance to Deadlines</b>  | cannot deal with deadline pressures             | occasionally deal with deadlines   | can deal with deadlines that are reoccurring                                    | can deal with strict deadlines   |
| <b>Attention to Detail</b><br>(indicate maximum time the Individual can concentrate) | concentration on detail is severely limited     | concentrate on detail is limited   | can concentrate on details, needs occasional breaks of non detailed work        | able to concentrate intensely on detailed work                           |
| <b>Performance of Multiple Tasks</b>   | can deal with one task at a time                | can handle more than 1 task but requires cues as to when to do task              | can handle multiple tasks requires some time management assistance              | fully able to handle multiple tasks without difficulty                   |
| <b>Tolerance to External Stimulus</b>  | needs quiet, non distracting work environment   | can cope with small degree of distraction  | can cope with distracting stimuli for portion of day                            | fully able to cope with multiple stimuli without negative effect         |
| <b>Ability to Work with Others Cooperatively</b>                                     | tolerates working alone                         | can tolerate others within vicinity, but needs to perform independent tasks      | can work with others cooperatively when required                                | fully able to work in close cooperation with others                      |
| <b>Confrontational Situations</b>  | unable to cope with confrontational situations  | can cope with exposure to confrontational situations with back-up available      | moderate ability to cope with confrontational situations                        | able to deal with confrontational situations with tact and control       |
| <b>Responsibility and Accountability</b>   | errors in judgment or attention likely to occur | can exercise a moderate level of responsibility with occasional need for support | can accept responsibility including the responsibility for the safety of others | can accept a high level of responsibility including sensitive situations |

**Prognosis** (based on objective assessments)

**From the date of this assessment, the above will apply for approximately:**

- 1-2 weeks   
 3-5 weeks   
 6-8 weeks   
 2-3 months   
 4-6 months  
 6+ months   
 Unknown

**Recommendations for work hours and start date:**

- Regular full time hours   
 Modified hours   
 Graduated hours

Start Date:

\_\_\_\_\_  
(dd/mm/yyyy)

**Next appointment date to review Limitations and/or Restrictions:**

\_\_\_\_\_  
(dd/mm/yyyy)

**Part 4 - Medical Practitioner – please complete the following:**

|  |   |  |   |
|--|---|--|---|
| <b>PHYSICAL LIMITATIONS AND/OR RESTRICTIONS</b> <input type="checkbox"/> N/A   |   |  |   |
| Please describe <b>physical</b> limitations and/or restrictions only. <b>Cognitive</b> limitations and/or restrictions, if any, can be detailed in Part 3. These physical restrictions will be assessed when determining modified work either in the employee’s own position or another suitable position. |   |  |   |
| <b>Date of Assessment:</b> _____<br>(dd/mm/yyyy)   |   |  |   |
| <b>Walking:</b><br><input type="checkbox"/> Full abilities<br><input type="checkbox"/> Up to 100 metres<br><input type="checkbox"/> 100 - 200 metres<br><input type="checkbox"/> Other (please specify) _____  | <b>Standing:</b><br><input type="checkbox"/> Full abilities<br><input type="checkbox"/> Up to 15 minutes<br><input type="checkbox"/> 15 - 30 minutes<br><input type="checkbox"/> Other (please specify) _____ | <b>Sitting:</b><br><input type="checkbox"/> Full abilities<br><input type="checkbox"/> Up to 30 minutes<br><input type="checkbox"/> 30 minutes - 1 hour<br><input type="checkbox"/> Other (please specify) _____ | <b>Lifting from floor to waist:</b><br><input type="checkbox"/> Full abilities<br><input type="checkbox"/> Up to 5 kilograms<br><input type="checkbox"/> 5 - 10 kilograms<br><input type="checkbox"/> Other (please specify) _____  |
| <b>Lifting from Waist to Shoulder:</b><br><input type="checkbox"/> Full abilities<br><input type="checkbox"/> Up to 5 kilograms<br><input type="checkbox"/> 5 - 10 kilograms<br><input type="checkbox"/> Other (please specify) _____  | <b>Stair Climbing:</b><br><input type="checkbox"/> Full abilities<br><input type="checkbox"/> Up to 5 steps<br><input type="checkbox"/> 5 - 10 steps<br><input type="checkbox"/> Other (please specify) _____ |  |   |
| <input type="checkbox"/> <b>Bending/twisting repetitive movement of</b><br><input type="checkbox"/> (please specify): _____  | <input type="checkbox"/> <b>Work at or above shoulder activity:</b><br>_____  | Limited pushing / pulling with:<br>Left Arm <input type="checkbox"/><br>Right Arm <input type="checkbox"/><br>Other (please specify) <input type="checkbox"/> _____  | <input type="checkbox"/> Limited use of hand(s):<br>Left <input type="checkbox"/> Right <input type="checkbox"/><br><input type="checkbox"/> Gripping <input type="checkbox"/><br><input type="checkbox"/> Pinching <input type="checkbox"/><br><input type="checkbox"/> Other <input type="checkbox"/> |
| <input type="checkbox"/> <b>Operating motorized Equipment</b>  | <input type="checkbox"/> <b>Environmental Exposure to: (heat, cold, noise)</b>  | <input type="checkbox"/> <b>Chemical exposure to:</b><br>_____   | <input type="checkbox"/> <b>Exposure to Vibration:</b><br>Whole body<br>Hand/arm  |
| <b>Other</b> (Please describe) _____   |   |  |   |
| <b>Prognosis - From the date of this assessment, the above will apply for approximately:</b>   |   |  |   |
| <input type="checkbox"/> 1-2 weeks <input type="checkbox"/> 3-5 weeks <input type="checkbox"/> 6-8 weeks <input type="checkbox"/> 2-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 6+ months <input type="checkbox"/> Unknown   |   |  |   |
| <b>Recommendations for work hours and start date:</b>  |   |  |   |
| <input type="checkbox"/> Regular full time hours <input type="checkbox"/> Modified hours <input type="checkbox"/> Graduated hours  |   |  | Start Date: _____<br>(dd/mm/yyyy)   |
| <b>Next appointment date to review Limitations and/or Restrictions:</b> _____<br>(dd/mm/yyyy)  |   |  |   |

Please provide any additional information/comments/findings/limitations (ex. Physical, Cognitive) which you feel would assist our employee in a safe and timely return to work.

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**PART 5 – Health Care Practitioner Information**

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|--|-------------------------------------|
| Health Care Practitioner Signature:        | Date Completed: _____<br>dd/mm/yyyy |
| Health Care Practitioner Name and Address: |                                     |