RAINY RIVER DISTRICT SCHOOL BOARD

MEDICAL CERTIFICATE - Confidential

Employee Name:	

MANDATORY

I, _____ authorize the release of the information requested on this Medical Certificate, in relation to the medical condition(s) currently impacting my ability to work, to the Rainy River District School Board, by my licensed physician, medical practitioner or health care professional who treats me.

I understand that the information provided by any health care professional will be used to assist in planning for my early and safe return to work, workplace accommodation and/or to determine my access to sick leave benefits.

_____ _____
Signature Date

OPTIONAL:

1. I authorize my employer to contact my healthcare professional to clarify any information contained on this form.

   Initial: _____

2. I authorize my healthcare professional to fax the completed form to the attention of **Alexandra Kozlowski**, Employee Relations & Wellness Consultant, at the confidential fax number: **807-274-1950**

   Initial: _____

Section A: Health Care Professional to complete. Please outline your patient's limitations and/or restrictions based on your objective medical findings.

Date of Assessment:	If limitations and/or restrictions apply, please complete Section B.:
dd mm yyyy	☐ **No current restrictions**.

Section B: Health Care Professional to complete. Please outline your patient's limitations and/or restrictions based on your objective medical findings (if applicable).

1. Nature of the illness or injury: _____

2. Is there a diagnosable condition? Yes _____ No_____

3. Based on this assessment date noted above and objective medical findings, please provide the cognitive and/or physical limitations/restrictions if any:_____
_____
_____
_____

4. Anticipated duration off of work:_____

5. (a) Is he/she receiving any current treatment? Yes _____ No_____

6. Has or will a referral to a specialist be made? Yes____ No____

7. Please provide comments you feel would be helpful in assisting our employee in a safe and timely return to work or accommodations:
_____
_____
_____

Section C: To Be Completed by Health Professional (Please Print)

Health Professional Name: _____ Telephone/Fax: _____

Address: _____

Signature: _____ Date: _____

REV: January 2020