RAINY RIVER DISTRICT SCHOOL BOARD

MEDICAL CERTIFICATE – SURGERY ONLY – CONFIDENTIAL

EMPLOYEE NAME:	**POSITION:**

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 health care professional to clarify any information contained on this form.

   Initial: _____

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

   Initial: _____

Health Care Professional to complete based on objective medical findings:

1. Date the employee is scheduled for/had surgery: (MM/DD/YYYY) _____

2. a) Date the employee will need/needed to be absent from work beginning: (MM/DD/YYYY) _____

b) If the first date of absence is not the date of surgery, please indicate the reason for the pre-surgery absence:
_____
_____

3. Nature of injury/illness: _____

4. Is there a diagnosable condition? Yes ☐ No ☐

5. What is the standard post-operative recovery period? _____

6. Will the employee be able to return to modified work duties or modified/graduated work hours prior to full recovery? Yes ☐ No ☐ If yes, when? _____

7. What physical and/or cognitive limitations/restrictions, if any, should be observed post-surgery and for how long?
_____
_____
_____

8. What is the date of the post-surgical follow-up appointment, if any? (MM/DD/YYYY) _____

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

PLEASE RETURN THE COMPLETED FORM TO OUR EMPLOYEE OR, WITH THEIR CONSENT, PLEASE SEND TO OUR CONFIDENTIAL HUMAN RESOURCES FAX NUMBER: 807-274-1950

Health Care Professional Name: _____ Telephone/Fax: _____

Address: _____

Signature: _____ Date: _____

REV: January 13, 2020