



## Medical Certificate of Disability and / or Return to Work (ETFO, PVP, AAPSP, Sr Admin)

In order to qualify for Sick Benefits, employees must provide a medical certificate from a qualified medical practitioner certifying that the employee is/was absent from work due to illness or injury. Your assistance in completing this form is appreciated.

Employee Name: \_\_\_\_\_

Occupation/Union: \_\_\_\_\_ Employee ID #: \_\_\_\_\_

Date(s) of Absence: From: \_\_\_\_\_ To: \_\_\_\_\_

Nature of Illness/Injury: \_\_\_\_\_

Employee:  Was/Is Under My Care  Advised Me of Absence on: \_\_\_\_\_

Other (please explain): \_\_\_\_\_

Employee is fit to return to full duties with no limitations on: \_\_\_\_\_

Employee is fit to return to **work with limitations**. *Please Complete Reverse Side.*

Employee is unable to return to work and will be reassessed next on: \_\_\_\_\_

**IF** the employee is **unable to return to any form of modified duties** (*see reverse side*), please explain what is preventing him/her from performing modified duties.

\_\_\_\_\_  
\_\_\_\_\_

Treatment Plan \_\_\_\_\_

\_\_\_\_\_

Medical Practitioner: \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Date: \_\_\_\_\_

Telephone No: \_\_\_\_\_

Fax: \_\_\_\_\_

I am authorizing the treating medical practitioner, as listed above, to provide the TVDSB, Abilities and Wellness Team with information regarding the **nature of my illness/injury** qualifying me for Sick Benefits, and/or my **Functional Abilities** with respect to returning to modified or full duties of work. I understand that no other confidential medical information will be released under this signature.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for your co-operation.

**Please submit to:**  
**Confidential Fax Line: 519-452-2606**  
**or Email: [medicalnote@tvdsb.ca](mailto:medicalnote@tvdsb.ca)**  
**Modified Return to Work**

The Thames Valley District School Board is committed to the successful rehabilitation of our employees. Our goal is to return each worker to employment as soon as possible following an injury/illness within his/her physical capabilities. Your participation in making this goal a reality for your patient is invited.

Depending upon your patient's present level of capabilities, please indicate what tasks he/she is capable of performing from his/her regular job, including modified or graduated hours. **The functional abilities information will be shared with the Principal or manager/supervisor.**

If you require further information regarding the Return to Work Program, please do not hesitate to contact Abilities & Wellness Services.

**EMPLOYEE NAME:** \_\_\_\_\_

May return to work on \_\_\_\_\_ with the following **restrictions:**

<p><b>WALKING</b></p> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 100 metres <input type="checkbox"/> 100 - 200 metres <input type="checkbox"/> Other (please specify):	<p><b>STANDING</b></p> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15 - 30 minutes <input type="checkbox"/> Other (please specify):	<p><b>SITTING</b></p> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 30 minutes <input type="checkbox"/> 30 min. - 1 hour <input type="checkbox"/> Other (please specify):	<p><b>LIFTING (from floor to waist)</b></p> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (please specify):								
<p><b>LIFTING (from waist to shoulder)</b></p> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (please specify):	<p><b>STAIR CLIMBING</b></p> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 steps <input type="checkbox"/> 5 - 10 steps <input type="checkbox"/> Other (please specify):	<p><b>LADDER CLIMBING</b></p> <input type="checkbox"/> Full abilities <input type="checkbox"/> 1 - 3 steps <input type="checkbox"/> 4 - 6 steps <input type="checkbox"/> Other (please specify):	<p><b>TRAVEL TO WORK</b></p> <table border="0"> <tr> <td>Ability to use public transit</td> <td>Ability to drive a car</td> </tr> <tr> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> Yes</td> </tr> <tr> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> No</td> </tr> </table>	Ability to use public transit	Ability to drive a car	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> No		
Ability to use public transit	Ability to drive a car										
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes										
<input type="checkbox"/> No	<input type="checkbox"/> No										
<input type="checkbox"/> <b>Bending / twisting</b> <input type="checkbox"/> <b>Repetitive movement of</b> (please specify):	<input type="checkbox"/> <b>Work at or above shoulder activity:</b>	<input type="checkbox"/> <b>Chemical exposure to:</b>	<input type="checkbox"/> <b>Environmental exposure to</b> (e.g. heat, cold, noise, or scents):								
<p><b>Limited use of hand(s):</b></p> <table border="0"> <tr> <td>Left</td> <td>Right</td> </tr> <tr> <td><input type="checkbox"/> Gripping</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Pinching</td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Typing</td> <td><input type="checkbox"/></td> </tr> </table>	Left	Right	<input type="checkbox"/> Gripping	<input type="checkbox"/>	<input type="checkbox"/> Pinching	<input type="checkbox"/>	<input type="checkbox"/> Typing	<input type="checkbox"/>	<p><b>Limited pushing/pulling with:</b></p> <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm	<p><b>Visual Restrictions</b></p> <input type="checkbox"/> <b>Voice Restrictions</b>	<p><b>Exposure to vibration</b></p> <input type="checkbox"/> <b>Whole body</b> <input type="checkbox"/> <b>Hand / Arm</b>
Left	Right										
<input type="checkbox"/> Gripping	<input type="checkbox"/>										
<input type="checkbox"/> Pinching	<input type="checkbox"/>										
<input type="checkbox"/> Typing	<input type="checkbox"/>										

**Cognitive / Mental**

- Attention/Concentration: \_\_\_\_\_
- Memory: \_\_\_\_\_
- Decision Making: \_\_\_\_\_
- Organization: \_\_\_\_\_
- Communication: \_\_\_\_\_
- Other: \_\_\_\_\_
- Modified Hours: \_\_\_\_\_
- Duration of Restrictions: \_\_\_\_\_