St. Paul Education Regional Division No. 1 4313-48 Avenue St. Paul, AB T0A 3A3	**Certificate of Extended Illness** (more than two weeks) **Human Resource Services**

TO THE PHYSICIAN:

___________________________ has been asked to provide a Medical Certificate explaining the reasons for absence and confirming that he/she is absent from duties for the purpose of obtaining necessary personal medical or dental treatment or because of accident, sickness or disability and therefore required a medical leave from his/her employment with St. Paul Education Regional Division No. 1.

Please note that this medical certificate, upon its completion, may be sent by the Board to its own external medical consultants for review. These medical consultants are governed by professional protocols concerning confidentiality.

EMPLOYEE'S AUTHORIZATION FOR RELEASE OF INFORMATION

It is understood that the employee has authorized his/her physician to complete the medical certificate herein contained, with the employee to arrange delivery of the form to St. Paul Education Regional Division No. 1.

Employee Name: ________________________________

Date of Examination: _____________________________

PHYSICIAN'S STATEMENT

Confirmation of Reasons for Medical Leave:

1. Following examination, I certify that the above mentioned person is ill or injured and requires a medical leave Yes _____ No ______ since (date) __________________.

2. Following examination, I certify that the above-mentioned person requires (or required) extended medical leave due to (explain the nature of the illness or disability; do not provide the diagnosis):

____

____

____

____

3. Is there a treatment plan in place? Yes_____ No______

4. Is the treatment plan being followed by the employee? Yes______ No______

5. Has this person been referred to a medical specialist? Yes______ No______

6. The following are the symptoms or the functional limitations associated with the illness, injury or treatment plan that are preventing the employee from completing his/her duties as a teacher:

____

____

____

____

NOTE: duties and work hours are variable depending on assignment and some accommodation is possible.

7. When this employee returns to work, I anticipate the following restrictions, if any (please include duty restrictions, maximum hours per day, and estimated length of time prior to resuming full duties):

____

____

____

____

8. If the individual is not currently capable of full-time work, can this person currently work on a part-time or a restricted basis?

Yes______ No______ (if yes, describe duty restrictions, maximum hours per day, etc.)

____

____

9. Anticipated date of return to work:

Date: _________________________

If date is unknown, is the absence likely to be:

______less than 30 days ______30-60 days ______61-90 days

______ more than 90 days ______ not yet determined

10. Is the absence a reoccurrence of an earlier illness or disability?

    Yes ______No ______

11. Did the medical disability arise as a result of any third party action?

    Yes______ No______

12. Anticipated date of next reassessment, if applicable:

    Date: ________________________

Dated _____________________20____

____
Attending Physician's Name (Please Print)

____

Signature of Physician

Address: __________________________

____

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Telephone: __________________________

Return: Personal/Confidential, Superintendent St. Paul Education 4313-48 Avenue St. Paul, AB T0A 3A3

The personal information on this form is collected under the authority of the Alberta Freedom of Information and protection of Privacy Act for the purpose of reporting non-work related illness or injury. If you have any questions about the collection, use or disclosure of this information, contact the Superintendent of Schools, 4313-48 Avenue, St. Paul, AB T0A 3A3 - Telephone (780) 645-3323.