St. Paul Education 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.

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.

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: _____

_____

_____

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.