

COLLEGE OF PHYSICIANS & SURGEONS OF BRITISH COLUMBIA

Excerpt from Policy Manual M-2

- Ensure that any statements which you make are, to the best of your knowledge, accurate and based upon current clinical information about the employee. For example, you should not certify that an employee has been unfit to work simply because the employee tells you so.
- Before giving an opinion on an employee's fitness to work, a physician should be sure that the physician has accurate information about the requirements of the employee's job.
- The physician should not state that the employee has been under the physician's care for any time during which the employee was not in fact the physician's patient.
- Physicians should ensure that they have received the employee's consent to provide information to the employer or its insurer.
- Physicians should take care not to disclose more information than is covered by the employee's consent or is required by the employer's request. For example, diagnosis and treatment information is not normally required to questions concerning fitness to work or prognosis for future attendance at work.

While reference in this article has been to forms required by a patient's employer or that employer's insurer, it is plain that the guidelines offered have just as ready application to the other sorts of forms which patients ask physicians to complete in order that patients can avail themselves of the benefits to which they may be entitled. No physician is immune from request to complete forms, and all physicians know how repetitive and tedious and time consuming this activity can be. The point is, however, that carelessness in the completion of forms can cause serious medico-legal difficulty for a physician, just as can carelessness in the management of a patient.



CONFIDENTIAL
SCHOOL DISTRICT NO. 71 (COMOX VALLEY)
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 Tel: (250) 334-5500 Fax: (250) 338-4961

**Medical Certificate
 Support for Workplace Accommodation**

To the Physician:
 _____ has been asked to provide a Medical Certificate explaining the reasons for the need for workplace accommodation from _____ to _____.
 (Date) (Date)

Employee's Authorization for Release of Information

I, _____ hereby authorize my physician to complete this Physician's Statement and to release this Medical Certificate to my Employer. The guidelines of the College of Physicians and Surgeons are attached.

Employee's Signature _____ Date _____

**Physician's Statement
 Confirmation of Reasons for Workplace Accommodation**

(MUST BE DUE TO A BONA FIDE ILLNESS OR INJURY)

1. Following examination, I certify that the above mentioned person, while able to work his/her full assignment, requires a workplace accommodation due to the following restrictions and/or limitations:

2. Course of Treatment:

a. Has this person been prescribed a course of treatment for the illness or disability requiring workplace accommodation?

b. If no course of treatment has been *prescribed*, has a course of treatment been *recommended* for this person to follow related to the medical condition requiring him/her to work his/her assignment with accommodation?

c. If a course of treatment has been prescribed or recommended, has this person followed the prescribed or recommended course of treatment?

d. Has this person been referred to a medical specialist?

Yes _____ No _____

3. He/she was seen by me regarding this illness/injury on _____ (Date).

4. What medical follow-ups, if any, are occurring related to this illness/injury?

5. I estimate that this person will be able to return to their full assignment without accommodation on _____ (Date).

Name of Attending Physician (please print)

Address _____

Postal Code _____ Phone _____

Signature _____

Date _____

OFFICE STAMP

The information in this report is considered confidential. Any charge for completion of this form is the responsibility of the claimant.