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)
607 Cumberland Road, Courtenay, B.C. V9N 7G5
Tel: (250) 334-5500 Fax: (250) 338-4961

Medical Certificate
Request for Partial Medical Leave of One Month or More

To the Physician:

____ has been asked to provide a Medical Certificate explaining the reasons for the need for partial medical leave from
_________________________ to ________________________.

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 *Partial* Medical Leave (One Month or More)

1. Following examination, I certify that the above mentioned person, while medically unable to work his/her full assignment, is capable of working part time on the following time basis:
   ____
   ____
   ____

2. I certify that the above mentioned person requires a partial medical leave due to:
   ____
   ____
   ____

3. Course of Treatment:
   a. Has this person been prescribed a course of treatment for the medical condition rendering him/her unable to work his/her full assignment?
      ____
      ____

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 rendering him/her unable to work his/her assignment?

____
____
____

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 _______

4. This illness/injury will prevent this person from working their full assignment because:

____
____
____

5. He/she was seen by me regarding this illness/injury on ___________________________.

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

____
____
____

7. I estimate that this person will be able to return to their full assignment on ____________________________.

8. Are there ways to address the medical cause of this person's application for partial medical leave by alterations to this person's assignment other than a reduced work load?

____
____
____

9. For informational purposes, this is to make you aware of the availability for employees of the Employee and Family Assistance Program (EFAP 1-866-644-0326).

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.