

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.



**COMOX VALLEY
SCHOOL DISTRICT**

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 OF ATTENDING PHYSICIAN FOR FULL RETURN TO WORK

_____ HAS BEEN EXAMINED BY THE UNDERSIGNED, AND I AM AWARE
(EMPLOYEE'S NAME) OF THE NATURE OF THE PATIENT'S EMPLOYMENT DUTIES
AND, IN PARTICULAR, OF THE PHYSICAL DEMANDS OF THOSE
DUTIES.

This person has been under treatment from _____ 20 _____
(DATE)

for _____ and will be medically fit
(MEDICAL CONDITION)

to return to work as a _____ effective _____
(POSITION) (DATE)

Without restrictions **OR**

Subject to the following accommodations (indicate the period of time the restrictions are in effect):

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.