



Please return to: **Greater Saskatoon Catholic Schools**
420 22nd St. East, Saskatoon, SK S7K 1X3
Attention – Human Resource Services

MEDICAL CERTIFICATE/ FUNCTIONAL ABILITIES FORM

CUPE / OUT-OF-SCOPE STAFF

This form **may** be required upon Board request for any illness in excess of three (3) working days in one (1) calendar month.

This form **shall** be completed for all illness-related absences of ten (10) days or more.

Patient/Employee's Name: _____

Employee Authorization – I consent to the release of the following information to my employer. The following information is required to allow my employer to assist me in returning to work or assisting in work accommodation as required.

Employee Signature

Date

MESSAGE TO PHYSICIANS – Greater Saskatoon Catholic Schools believes employee wellness, in most situations, is best furthered through returning to work as soon as possible under the direction of guidance of a health care practitioner following an illness or injury.

Greater Saskatoon Catholic Schools is committed to making necessary accommodations to support an early return to work. Accommodations can include reduced hours and/or modified duties for a specified period of time. Should you have any questions regarding return to work options please contact our Benefits Administrator at 659-7015.

Date of initial contact with the patient regarding this illness/injury: _____ / _____ / _____
Day Month Year

Are you aware of other Health Care Providers treating this patient? Yes No If yes, whom? _____

Please indicate **Abilities** that apply. Include additional details as appropriate. The patient/employee is capable of:

- | | | | |
|--|---|--|--|
| Walking: | Standing: | Sitting: | Lifting from floor to waist: |
| <input type="checkbox"/> Full abilities | <input type="checkbox"/> Full abilities | <input type="checkbox"/> Full abilities | <input type="checkbox"/> Full abilities |
| <input type="checkbox"/> Up to 100 metres | <input type="checkbox"/> Up to 15 minutes | <input type="checkbox"/> Up to 30 minutes | <input type="checkbox"/> Up to 5 kilograms |
| <input type="checkbox"/> 100 – 200 metres | <input type="checkbox"/> 15 – 30 minutes | <input type="checkbox"/> 30 minutes – 1 hour | <input type="checkbox"/> 5 – 10 kilograms |
| Lifting from waist to shoulder: | Stair climbing: | Ladder climbing: | |
| <input type="checkbox"/> Full abilities | <input type="checkbox"/> Full abilities | <input type="checkbox"/> Full abilities | |
| <input type="checkbox"/> Up to 5 kilograms | <input type="checkbox"/> Up to 5 steps | <input type="checkbox"/> 1 – 3 steps | |
| <input type="checkbox"/> 5 – 10 kilograms | <input type="checkbox"/> 5 – 10 steps | <input type="checkbox"/> 4 – 6 steps | |

Please indicate **Restrictions** that apply. Include additional details as appropriate:

- | | | | | |
|---|---|---|--|--|
| <input type="checkbox"/> Bending/twisting repetitive movement of _____ (please specify) | <input type="checkbox"/> Work at or above shoulder activity: | <input type="checkbox"/> Chemical exposure to: | <input type="checkbox"/> Environmental exposure to: (e.g. heat, cold, noise or scents) | <input type="checkbox"/> Limited use of hand(s):
Left
<input type="checkbox"/> Gripping
<input type="checkbox"/> Pinching
<input type="checkbox"/> Other (please specify) <input type="checkbox"/> |
| <input type="checkbox"/> Limited pushing/pulling with:
<input type="checkbox"/> Left arm
<input type="checkbox"/> Right arm
<input type="checkbox"/> Other _____ | <input type="checkbox"/> Operating motorized equipment: (e.g. floor polisher) | <input type="checkbox"/> Exposure to vibration:
<input type="checkbox"/> Whole body
<input type="checkbox"/> Hand/Arm | | |

Additional Comments on **Abilities and/or Restrictions:**

From the date of this assessment, the above will apply for approximately:

1 – 2 days 3 – 7 days 8 – 14 days 14 + days

Have you discussed return to work with your patient? Yes No



Greater Saskatoon Catholic Schools recognizes, in some circumstances, employees are unable to return to current or modified duties for a period of time. Is this the case for this employee? Yes No

If yes, please list the medical condition(s) which have resulted in this determination:

Date of next review: _____

Anticipated date employee will return to modified duties: _____

Anticipated date employee will return to full duties: _____

Additional comments:

Physician's Name

Physician's Signature

Date

Physician's Phone Number

Physician's Address



MEDICAL CERTIFICATE JOB INFORMATION WORKSHEET

(To Be Completed by Employee)

Employee Name: _____ Date: _____

Job Title: _____

1. How many hours do you work at your job each week, not including lunch or coffee breaks? _____

2. How long are your daily breaks at work? _____

3. What are the most physically demanding tasks you do?

4. How often do you perform these tasks? _____

Employee Signature

Supervisor Signature

Employee is to:

- Complete and have form signed by immediate supervisor.
- Submit one copy of this form to Human Resource Services.
- Share and discuss the form with his/her physician.