Université d'Ottawa | University of Ottawa

CONFIDENTIAL

MEDICAL CERTIFICATE

EMPLOYEE'S STATEMENT

		OCC. HEALTH FILE NO.
SURNAME	GIVEN NAMES	EMPLOYEE NO.
PERMANENT HOME ADDRESS		TEL. NO.
FACULTY, SCHOOL, SERVICE	DEPARTMENT, DIVISION, SECTION	TEL. NO.
DATE OF BIRTH (YEAR / MONTH / DAY)	SUPERVISOR	

BRIEFLY DESCRIBE THE NATURE OF YOUR JOB (i.e., HEAVY OR MODERATE PHYSICAL ACTIVITY, MANUAL OR SEDENTARY WORK)

COMPLETE THIS SECTION IF DISABILITY IS THE RESULT OF AN ACCIDENT

DATE OF ACCIDENT (YEAR / MONTH / DAY)	TIME OF ACCIDENT ☐ A.M. ☐ P.M.	LOCATION OF ACCIDENT ☐ AT WORK ☐ OTHER (SPECIFY):

ARE YOU RECEIVING DISABILITY BENEFITS FROM ANY SOURCES OTHER THAN FROM THE UNIVERSITY OF OTTAWA?

COMMENTS

I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND AUTHORIZE THE PHYSICIAN, NAMED ON THIS FORM, TO COMPLETE THE ATTACHED ATTENDING PHYSICIAN'S STATEMENT FOR SUBMISSION TO THE HEALTH AND WELLNESS SECTOR OF THE UNIVERSITY OF OTTAWA.

DATE **SIGNATURE**

FOR EMPLOYER'S USE ONLY

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HUMAN RESOURCES
HEALTH AND WELLNESS
550 CUMBERLAND STREET, ROOM 017, OTTAWA (ONTARIO) CANADA K1N 6N5
TEL. NO.: 613-562-5800 ext. 1473, FAX NO.: 613-562-5120

uOttawa

ATTENDING PHYSICIAN'S STATEMENT

CONFIDENTIAL

PATIENT'S NAME

DATE OF BIRTH — YEAR / MONTH / DAY

1. IS THE DISABILITY DUE TO SICKNESS OR AN INJURY ARISING FROM THE PATIENT'S WORK? ☐ NO ☐ YES ☐ UNKNOWN

2a) SYMPTOMS FIRST APPEARED OR ACCIDENT HAPPENED ON .... YEAR / MONTH / DAY

2b) HAS THE PATIENT HAD THE SAME CONDITION IN THE LAST 30 CALENDAR DAYS? .... ☐ NO ☐ YES WHEN? .... YEAR / MONTH / DAY

DETAILS

3a) DATE OF THE FIRST VISIT FOR PRESENT PERIOD OF DISABILITY — YEAR / MONTH / DAY

3b) DATE OF LAST VISIT .... YEAR / MONTH / DAY

3c) WERE YOU ACTIVELY SUPERVISING THIS PATIENT'S CARE DURING THE FULL PERIOD?

☐ YES ☐ WEEKLY ☐ MONTHLY ☐ NO SPECIFY :

4a) LIKELY DATE OF ADMISSION TO HOSPITAL (IF APPLICABLE) — YEAR / MONTH / DAY

4b) LIKELY DATE OF DISCHARGE FROM HOSPITAL — YEAR / MONTH / DAY

5. WAS SURGERY PERFORMED? ☐ NO ☐ YES — YEAR / MONTH / DAY

DETAILS

6. WAS THIS PATIENT REFERRED TO YOU BY ANOTHER PHYSICIAN? ☐ NO ☐ YES

NAME OF PHYSICIAN

7. IS THE CONDITION DUE TO PREGNANCY? ☐ NO ☐ YES IF YES, WHAT IS OR WAS THE EXPECTED DATE OF DELIVERY? .... YEAR / MONTH / DAY

8a) TO THE BEST OF YOUR KNOWLEDGE, THE PATIENT WAS TOTALLY DISABLED (UNABLE TO PERFORM ANY TYPE OF WORK AND PURSUE STUDIES)

FROM — YEAR / MONTH / DAY TO — YEAR / MONTH / DAY

8b) TO THE BEST OF YOUR KNOWLEDGE, THIS PATIENT WILL BE ABLE TO RETURN TO WORK ON — YEAR / MONTH / DAY ☐ FULL-TIME ☐ PART-TIME

9a) HOW DOES THE PRESENT CONDITION AFFECT THE PATIENT'S ABILITY TO WORK?

9b) THE UNIVERSITY OF OTTAWA OFFERS A TRANSITIONAL WORK PROGRAM TO ACCOMMODATE EMPLOYEES WHO REQUIRE MODIFIED DUTIES AND/OR WORK HOURS.

WHAT ARE THE PATIENT'S CURRENT LIMITATIONS?

PHYSICAL FUNCTIONAL LIMITATIONS

- ☐ SITTING
- ☐ STANDING
- ☐ WALKING
- ☐ LIFTING
- ☐ CARRYING
- ☐ PUSHING / PULLING
- ☐ OTHER (SPECIFY IN SECTION 9c)

COGNITIVE FUNCTIONAL LIMITATIONS

- ☐ THINKING / REASONING
- ☐ CONCENTRATION
- ☐ MEMORY
- ☐ CRITICAL DECISION-MAKING
- ☐ ALERTNESS
- ☐ OTHER (SPECIFY IN SECTION 9c)

9c) DETAILS

10 THE ABOVE FONCTIONAL LIMITATIONS WILL BE IN PLACE UNTIL .... YEAR / MONTH / DAY

COMMENTS

NAME OF PHYSICIAN (PRINT)

ADDRESS

DATE

SIGNATURE (PHYSICIAN)