DALHOUSIE UNIVERSITY

Facilities Management

Physician's Certificate of Illness Form

Section 1: To Be Completed by Employee (Please Print)

Employee's Name:	Unit:	Classification:
Home Address:		
Date Absence Began: DD/MM/YYYY:_____		Date Absence Ended: DD/MM/YYYY: _____
Physician's Name:	Address:	Telephone Number:
I request the above named physician to complete the information listed below, and I authorize its release to my employer. Signature (Employee): X_____		Date: X_____

Section 2: Job Description Information

Job Title: Custodian

Job Summary (not in order of priority):

- Dusts horizontal and vertical surfaces
- Sweeps/dry-mops and wet-mops floors and stairways using dust mops, lamello tools, buckets, wringers, wet mops and automatic floor machines, as required
- Vacuums mats and carpeted areas
- Cleans and disinfects washroom surfaces and replenishes paper, plastic and soap supplies
- Removes refuse from domestic size containers and transfers bagged or loose waste to exterior dumpsters and waste holding sites
- Transfers recyclables/organic waste to designated holding site
- Cleans and polishes glass doors and partitions
- Strips and waxes floors and baseboards using appropriate power equipment
- Wall and ceiling washing using ladders, as necessary
- Arranges furniture (event set-ups) in designated areas
- Clears building entrances (exterior steps and landings) of snow, ice, cigarette butts and other debris
- Replaces light bulbs, as required
- Maintains a clean work environment
- Performs other duties as required
- Frequency lifts between 10 and 20 pounds

Physical Demands:

See attached

Section 3: To Be Completed by Physician

I have seen the above named person during the period of his/her absence from work: ☐ Yes ☐ No

The above named person has a diagnosed illness or injury: ☐ Yes ☐ No

Please indicate date and time of office visit(s) Date(s):_____ Time(s):_____

Nature of illness:_____

Could the above named person attend work immediately, or at an earlier date than currently anticipated to perform modified duties? ☐ Yes ☐ No

If yes, when and what accommodations would you recommend?

If no, what is the estimated date of return to work at full time duties or graduated return to work schedule?

Signature (Physician): X_____ Date: X_____

For patient confidentiality, please submit form to:

Nancey Roach, RN, COHN(C)
Disability Coordinator
Human Resources, Dalhousie University
Confidential Fax: (902) 494-7864
Phone: (902) 494-4351