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: General Foreperson

Job Summary:

- Co-ordinates single and multi-trade shop work
- Assigns work to and supervises W/F
- Evaluates W/F performance in supervising staff and projects
- Participates in evaluations of probationary employees
- Arranges for equipment rentals
- Co-ordinates overtime distribution as required
- Ensures trades daily time entry is accurate, complete and approved utilizing FAMIS
- Utilizing FAMIS, may generate PReqs; authorizing invoices for payment to a financial limit as delegated by Financial Services.
- In the absence of a supervisor attends weekly Resource Scheduling Meetings
- Advises supervisor of staffing complement requirements
- Ensures staff are properly trained, adequately skilled and match the tasks at hand
- Utilizing FAMIS, plans ahead and expedites work to ensure staff time, material, and other resources are utilized to maximize efficiency and effectiveness
- Ensures FM Safety Program and all relevant safety legislation is adhered to
- Participates in meetings as required
- Performs W/F duties as required
- Performs other duties as assigned

Physical Demands:

Lifting/Carrying	N/A	0 - 10 lbs.	11 - 20 lbs.	21 - 50 lbs.	> 50 lbs.	Frequency
Lifting - Floor to Waist	☑					N/A
Lifting - Waist to Shoulder	☑					N/A
Lifting - Above Shoulder	☑					N/A
Lifting - Carrying	☑					N/A

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