



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: Industrial Millwright/Machinist

Job Summary:

- Maintains, troubleshoots, repairs, replaces and installs motors, pumps, fans, compressors, emergency generators and other related rotating equipment on campus
- Assists in the organization of preventive maintenance and the scheduling of repairs to rotating equipment
- Recommends equipment upgrades based on best economical/professional judgment
- Performs all duties in accordance with the current Nova Scotia Occupational Health and Safety Act as well as University and Government rules and regulations
- Maintains a clean work environment
- Assists other tradespersons as required
- Performs other duties as required

Physical Demands:

Lifting/Carrying	N/A	0 - 10 lbs.	11 - 20 lbs.	21 - 50 lbs.	> 50 lbs.	Frequency
Lifting - Floor to Waist					<input checked="" type="checkbox"/>	Frequent
Lifting - Waist to Shoulder				<input checked="" type="checkbox"/>		Frequent
Lifting - Above Shoulder				<input checked="" type="checkbox"/>		Frequent
Lifting - Carrying					<input checked="" type="checkbox"/>	Frequent

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**