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: Insulator

Job Summary (not in order of priority):

- Maintains, plans, inspects, removes and installs insulation on pipe and related equipment
- Determines the quantity and type(s) of insulation required and the best method(s) of installation
- Measures, cuts and fits insulation around obstructions and shapes the insulation and protective coverings as required
- Removes and/or seals insulation, including asbestos, on pipe and equipment in accordance with industry standards and best practices
- Makes recommendations for upgrading insulation 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 related duties

Physical Demands:

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