

## 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: Maintenance Mechanic**
**Job Summary:**

- Performs routine maintenance checks on building mechanical systems
- Carries out preventive maintenance and minor repairs to mechanical systems as required
- Responds to calls related to mechanical systems problems
- Advises when mechanical problems have to be attended to by other trades
- Makes recommendations for upgrading mechanical systems based on best economical judgment
- Assists other tradespeople as required
- Performs all duties in accordance with the current Nova Scotia Occupational Health & Safety Act, as well as University and Government rules and regulations
- Maintains a clean work environment
- Assists 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"/>					N/A
Lifting - Waist to Shoulder	<input checked="" type="checkbox"/>					N/A
Lifting - Above Shoulder	<input checked="" type="checkbox"/>					N/A
Lifting - Carrying	<input checked="" type="checkbox"/>					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**