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: Plumber Aquatron Laboratory

Job Summary:

- Plans, installs, maintains and/or removes mechanical components of the Aquatron system. This includes seawater intakes, piping, tanks, valves, pumps, filters, compressors, heat exchangers, and associated equipment.
- Supervises work done by Aquatron technicians, which may include planning, installation, maintenance and/or removal of mechanical components of the Aquatron system. This includes seawater intakes, piping, tanks, valves pumps, filters, compressors, heat exchangers, and associated equipment.
- Performs all duties in accordance with the Nova Scotia Occupational Health and Safety Act, as well as University and Government rules and regulations.
- Specifies and obtains supplies as required.
- Coordinates, cooperates and assists Facilities Management staff as required.
- Assists users (undergraduate and graduate students, and principal investigators) of the Aquatron to facilitate research and ongoing operations as required.
- Performs stand-by and weekend duties as assigned by the Aquatron Manager.
- 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	☑					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