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:<br>DD/MM/YYYY:_____ | | Date Absence Ended:<br>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.<br>Signature (Employee): X_____ Date: X_____ | | |

**Section 2: Job Description Information**

**Job Title: Sprinkler Fitter**

Job Summary:

- Assembles, installs, tests, repairs, performs alterations, upgrades, troubleshoots, and maintains sprinkler systems
- Installs and/or repairs fire protection and fire control systems
- Connects equipment and fittings to piping systems
- Tests sprinkler and fire protection systems
- Performs all duties in accordance with the current Nova Scotia Occupational Health & Safety Act, as well as University and Government rules and regulations
- Prepares and maintains appropriate records of inspections and tests performed
- 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 | | | | ☑ | | 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**