



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): <u>X</u> _____		Date: <u>X</u> _____	

Section 2: Job Description Information

Job Title: Storeperson 1

Job Summary:

- Directs the activity of Storeperson(s) 2 and/or Helper(s)
- Monitors and reviews inventory levels
- Maintains current material catalog database in FAMIS
- Maintains an up-to-date list of obsolete and on hand specialty items
- Supervises and participates in cycle and annual inventory counts
- Prepares, monitors, reviews and expedites orders utilizing FAMIS
- Issues and returns stock utilizing FAMIS
- Communicates with vendors regarding orders, pricing problems, deliveries, etc.
- Receives, stores and documents orders received
- Ensures paper work is performed accurately and in a timely fashion
- Reports vendor problems to supervisor
- Maintains a Hazardous Materials Log
- Arranges trucking pick-up and delivery of materials
- Arranges for rental of equipment
- Ensures stock room is maintained in a clean and orderly condition
- Maintains Clothes and Tools Issues report
- Coordinates cleaning, repairs and replacement of tools and reports tool misuse
- Maintains protective safety clothing and any equipment inventory
- Ensures that stock is labeled correctly
- 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
- 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"/>		Infrequent
Lifting - Waist to Shoulder			<input checked="" type="checkbox"/>			Infrequent
Lifting - Above Shoulder		<input checked="" type="checkbox"/>				Infrequent
Lifting - Carrying				<input checked="" type="checkbox"/>		Infrequent

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**