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: Utility Service Person (USP)

Job Summary:

- Accompanies and assists trades staff, project leaders, consultants and contractors as required
- Maintains and repairs non-electrical components of light fixtures (bulbs, shades, etc.)
- Maintains a clean work environment
- Properly disposes of used lamps and maintains adequate stock levels, including ballasts
- Conducts field audits to gather applicable information pertaining the creation and modification of PM routines
- Performs all duties in accordance with the current Nova Scotia Occupational Health and Safety Act as well as
- University and government rules and regulations
- Performs PM inspections on interior, exterior, emergency and exit lights, emergency showers and washrooms
- Follows up on deficiencies identified during PM inspections and refers certified trades work to Zone Supervisor,
- applicable trades person and/or client reception for action
- Performs other related duties as required
- May be required to perform minor maintenance tasks limited to:
    - Cleans pits and drainage areas as required
    - Cleans and inspects roofs, including drains and gutters
    - Cleans and maintains mechanical rooms
    - Removes graffiti utilizing appropriate products and techniques
    - Plunges toilets

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