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 - HVAC

Job Summary:

- Reviews the Maintenance Request Forms, identifies whether problems can be repaired by the USP or a tradesperson
- Makes recommendations for general maintenance repairs
- Performs routine inspections of Housing & Conference's buildings and grounds areas
- Greets tradespeople and external contractors (normally assigned by the Department of Facilities Management) unfamiliar with the building to show them the problem areas requiring their expertise as required
- Purchases all supplies through the Department of Facilities Management with storage available in Howe and Shirreff Halls
- Carries contact radio/beeper at all times during normal working hours
- Performs other related 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