Form 455 2.1 LCSD Support Staff - Physician Medical Restriction

Lloydminster Catholic School Division, 6611B – 39 Street, Lloydminster, AB T9V 2Z4

Employee Name:_____ Date of Birth _____

Employee Authorization
I consent to the release of the following information to my employer. The following information is required to allow my employer to assist me in returning to work or assisting in work accommodation as required.

Employee Signature _____ Date: _____

Medical Certificate: Return to Work

1. Date of last attendance on *Name of Employee*:_____
   Date of next clinical review: _____

2. Has *Name of Employee* been referred to a specialist who would have relevant information concerning the issues discussed in this report?
   No _____ Yes _____ to Dr. _____

3. In your opinion is *Name of Employee* fit for fulltime duties?
   Yes_____ No_____

   If "No"
   a) In your opinion on what date can we expect *Name of Employee* will be fit for full time duties: _____

   b) Please identify the specific restrictions or limitations that would prevent him/her from fulfilling his/hers duties:
   _____
   _____
   _____
   _____
   _____
   _____

4. Please provide any additional information that you feel would be pertinent and beneficial in order to facilitate *Name of Employee's* return to work:
   _____
   _____
   _____
   _____

Signature of Physician_____ Date: _____