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. Position of *Employee*: _____

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

3. Has the *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 *Employee* fit for fulltime duties?
   Yes_____ No_____

   If "No"

Nature of restriction	**Expected duration**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

(Attached is a form that you may choose to utilize if it would assist you in providing the requested information)

4. In your opinion on what date can we expect the *Employee* to be fit for full time duties with no medical restrictions: _____

5. Is the *Employee* currently on a course of treatment that involves prescription drugs or over-the-counter medications that carry any warnings or precautions that may be relevant in the performance of duties, or which could affect the safety or the *Employee* or others?
   Yes _____ No _____
   If yes, please describe any limitations:_____
   _____
   _____

6. Please provide any additional information that you feel would be pertinent and beneficial to access the employee's ability to return to work without causing harm to the employee's health or others:
   _____
   _____
   _____

Please identify the specific medical restrictions or limitations that would interfere with the ability of the employee to complete duties or perform some aspects of the *employee's* position as identified above in #1.

Motor or Physical	**Expected Duration**
○ Difficulty standing	_____
○ Length of time_____	
○ Difficulty bending to assist students, obtain materials, access files, etc.	_____
○ Difficulty sitting for long periods of time at tables or desks	_____
○ Difficulty moving around a room, school, grounds	_____
○ Difficulty writing on a chalk / white board	_____
○ Difficulty using a keyboard	_____
○ Difficulty writing on paper	_____
○ Difficulty Lifting	
#pounds /kgs _____	_____
Restricted movement _____	_____
○ _____	_____
○ _____	_____
○ _____	_____

Sensory	**Expected Duration**
○ Vision	
○ Difficulty viewing computer screens, obtaining information from a computer screen	_____
○ Difficulty viewing papers	_____
○ _____	_____
○ _____	_____
○ Hearing/ Speaking	
○ Difficulty communicating with others	_____
○ Difficulty accessing information from video / computer / tape	_____
○ Difficulty communicating using a telephone /skype / zoom	_____
○ Difficulty responding to fire and emergency signals	_____
○ Difficulty speaking in voice appropriate for others	_____
○ _____	_____
○ _____	_____

Allergies / Chemical Sensitivities	**Expected Duration**
○ Products used in schools:	_____
○ Chalk	_____
○ Cleaning products	_____
○ Perfumes	
○ _____	_____
○ _____	_____
○ _____	_____
○ _____	_____
○ _____	_____

Cognitive	**Expected Duration**
○ Maintaining Stamina	_____
○ Difficulty with concentration	_____
○ Difficulties increased by:	
○ Artificial Lighting	_____
○ Clutter	_____
○ Interrupted work time	_____
○ Self-directed assignments	_____
○ Distractions in the work area	_____
○ Difficulty with organization	_____
○ Difficulty with staying on task	_____
○ Difficulty with managing time	
○ Difficulty with finishing paperwork	_____
○ Memory deficits	_____
○ _____	_____
○ _____	_____

Psychosocial or Social-Emotional	**Expected Duration**
○ Difficulty handling stress and emotions	_____
○ Difficulty interacting with co-workers	_____
○ Difficulty handling changes in the workplace	_____
○ _____	_____
○ _____	_____
○ _____	_____

Other Restrictions

○ _____	_____
○ _____	_____
○ _____	_____

Name of Physician: _____

Signature of Physician: _____ **Date**: _____