

**This Medical Certificate is required of employees who are able to work temporary modified duties.**

*If an employee is able to return to full duties following an extended absence,  
a physician's note stating "Return to work, with no restrictions", is all that is required.*

**EMPLOYEE / PATIENT INFORMATION: (Please Print)**

|                     |             |           |
|---------------------|-------------|-----------|
| Surname:            | Given Name: | Date:     |
| Job Title:          | Site:       | Hours/wk. |
| Employee Signature: |             |           |

*\*All fees incurred for the completion of this medical certificate are at the expense of the employee.*

**Fitness for Work** (to be completed by treating health care provider)

Examination date: \_\_\_\_\_

☐ fit for temporary modified work. *\*Complete Functional Restrictions/Limitations below.*

☐ not capable of any work from \_\_\_\_\_ to \_\_\_\_\_  
*\*Please maintain regular contact with your employer.*

Date of next Medical appointment: \_\_\_\_\_

**Functional Restrictions / Limitations for MODIFIED WORK: (Request patient Job Description)**

| Activity  | Limitation                              | Activity      | Limitation  |
|-----------|---|---------------|-------------|
| Bending   |   | Sitting       |             |
| Climbing  |   | Squatting     |             |
| Crawling  |   | Standing      |             |
| Equipment | (operating)                             | Stooping      |             |
| Heights   |   | Twisting      |             |
| Kneeling  |   | Vehicle       | (operating) |
| Lifting   | Up to: 4.5 kg / 9.1 kg / 23 kg / 45+ kg | Walking       |             |
| Pulling   | Up to: 4.5 kg / 9.1 kg / 23 kg / 45+ kg | Mental Health |             |
| Pushing   | Up to: 4.5 kg / 9.1 kg / 23 kg / 45+ kg | Other         |             |

**EFAP Supports:**      ATA - Homewood Health      CUPE - Borealis Counselling Services

Additional Information:

\_\_\_\_\_

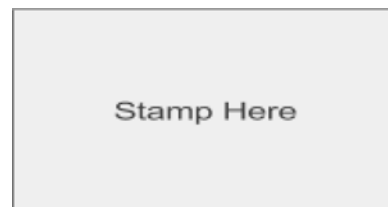
\_\_\_\_\_

Prognosis for return to work, no restrictions: \_\_\_\_\_ (date)

Attending Health Care Provider:

\_\_\_\_\_  
Name(Print)

\_\_\_\_\_  
Signature



***The information in this certificate is considered confidential.***