This form shall be provided by the medical practitioner to the employee who will then deliver it to the Human Resources Department.

Medical Certificate – OECTA

Part 1 – Employee - please complete following:

_____
(Employee Name)

The information supplied will be used in a confidential manner and may assist in creating a return to work plan.

I hereby consent to the completion of this form by:

_____
(Treating Medical Practitioner's Name)

☐ Absent from Work _____
(first date of absence)

☐ Not absent from work but requires accommodations

_____ _____
(Signature of Employee) (Date)

Part 2 – Medical Practitioner – please complete the following

1. Nature of Illness (do not provide diagnosis):

_____

*** "Nature of the illness"(or injury) suggests a general statement of a person's illness or injury in plain language without any technical medical details, including diagnosis or symptoms. Although revealing the nature of an illness may suggest the diagnosis, it will not necessarily do so. "Nature of illness" and "diagnosis" are not congruent terms. For example, a statement that a person has a cardiac or abdominal condition or that s/he has undergone surgery in that respect reveals the essence of the situation without revealing a diagnosis**.

2. Is this condition the result of: (check one)

☐ Non-occupational illness/injury ☐ Occupational illness/injury

3. Is he/she receiving treatment: ☐ Yes ☐ No

4. Has or will a referral to a specialist been made? ☐ Yes ☐ No

   If yes, date of referral: _____
   (dd/mm/yyyy)

5. Have you discussed return to work with your patient? ☐ Yes ☐ Not at this time

6. Is the patient able to return to work: ☐ with accommodation ☐ without accommodation

   Expected date of return: _____
   (dd/mm/yyyy)

   ☐ unable to return to work at this time

7. Date of next assessment: _____
   (dd/mm/yyyy)

Part 3 and/or 4 need only be completed for a return to work that requires an accommodation.

Part 5 below is to be completed.

Part 3 – Medical Practitioner – please complete the following:

COGNITIVE LIMITATIONS AND/OR RESTRICTIONS ☐ N/A

Please describe **cognitive** limitations and/or restrictions. Physical limitations and/or restrictions, if any, can be detailed in Part 4. These cognitive restrictions will be assessed when determining modified work either in the employee's own position or another suitable position.

Date of Assessment: _____
(dd/mm/yyyy)

Level of Functioning (Please circle which level applies for each task)	***LEVEL 1***	***LEVEL 2***	***LEVEL 3***	***LEVEL 4***
Supervision Required	needs constant supervision	needs frequent supervision	needs limited supervision	requires no supervision
Supervision of Others	not able to supervise others	can meet demands of or for occasional supervision	can meet demands of or for regular supervision	can meet demands of full supervision
Tolerance to Deadlines	cannot deal with deadline pressures	occasionally deal with deadlines	can deal with deadlines that are reoccurring	can deal with strict deadlines
Attention to Detail (indicate maximum time the Individual can concentrate)	concentration on detail is severely limited	concentrate on detail is limited	can concentrate on details, needs occasional breaks of non detailed work	able to concentrate intensely on detailed work
Performance of Multiple Tasks	can deal with one task at a time	can handle more than 1 task but requires cues as to when to do task	can handle multiple tasks requires some time management assistance	fully able to handle multiple tasks without difficulty
Tolerance to External Stimulus	needs quiet, non distracting work environment	can cope with small degree of distraction	can cope with distracting stimuli for portion of day	fully able to cope with multiple stimuli without negative effect
Ability to Work with Others Cooperatively	tolerates working alone	can tolerate others within vicinity, but needs to perform independent tasks	can work with others cooperatively when required	fully able to work in close cooperation with others
Confrontational Situations	unable to cope with confrontational situations	can cope with exposure to confrontational situations with back-up available	moderate ability to cope with confrontational situations	able to deal with confrontational situations with tact and control
Responsibility and Accountability	errors in judgment or attention likely to occur	can exercise a moderate level of responsibility with occasional need for support	can accept responsibility including the responsibility for the safety of others	can accept a high level of responsibility including sensitive situations

Prognosis (based on objective assessments)
From the date of this assessment, the above will apply for approximately:

☐ 1-2 weeks ☐ 3-5 weeks ☐ 6-8 weeks ☐ 2-3 months ☐ 4-6 months

☐ 6+ months ☐ Unknown

Recommendations for work hours and start date:

☐ Regular full time hours ☐ Modified hours ☐ Graduated hours

Start Date: _____
(dd/mm/yyyy)

Next appointment date to review Limitations and/or Restrictions: _____
(dd/mm/yyyy)

Part 4 - Medical Practitioner – please complete the following:

PHYSICAL LIMITATIONS AND/OR RESTRICTIONS ☐ N/A

Please describe **physical** limitations and/or restrictions only. **Cognitive** limitations and/or restrictions, if any, can be detailed in Part 3. These physical restrictions will be assessed when determining modified work either in the employee's own position or another suitable position.

Date of Assessment: _____
(dd/mm/yyyy)

Walking:
☐ Full abilities
☐ Up to 100 metres
☐ 100 - 200 metres
☐ Other (please specify)

_____

Standing:
☐ Full abilities
☐ Up to 15 minutes
☐ 15 - 30 minutes
☐ Other (please specify)

_____

Sitting:
☐ Full abilities
☐ Up to 30 minutes
☐ 30 minutes - 1 hour
☐ Other (please specify)

_____

Lifting from floor to waist:
☐ Full abilities
☐ Up to 5 kilograms
☐ 5 - 10 kilograms
☐ Other (please specify)

_____

Lifting from Waist to Shoulder:
☐ Full abilities
☐ Up to 5 kilograms
☐ 5 - 10 kilograms
☐ Other (please specify)

_____

Stair Climbing:
☐ Full abilities
☐ Up to 5 steps
☐ 5 - 10 steps
☐ Other (please specify)

_____

☐ **Bending/twisting repetitive movement of** (please specify)**:**

_____

☐ **Work at or above shoulder activity:**

_____

☐ Limited pushing / pulling with:
☐ Left Arm
☐ Right Arm
☐ Other (please specify)

_____

☐ Limited use of hand(s):

Left	Right
☐ Gripping	☐
☐ Pinching	☐
☐ Other	☐

_____

☐ **Operating motorized Equipment**

☐ **Environmental Exposure to: (heat, cold, noise)**

☐ **Chemical exposure to:**

_____

☐ **Exposure to Vibration:**
☐ Whole body
☐ Hand/arm

Other (Please describe)

Prognosis - From the date of this assessment, the above will apply for approximately:

☐ 1-2 weeks ☐ 3-5 weeks ☐ 6-8 weeks ☐ 2-3 months ☐ 4-6 months ☐ 6+ months ☐ Unknown

Recommendations for work hours and start date:

☐ Regular full time hours ☐ Modified hours ☐ Graduated
hours

Start Date: _____
(dd/mm/yyyy)

Next appointment date to review Limitations and/or Restrictions: _____
(dd/mm/yyyy)

Please provide any additional information/comments/findings/limitations (ex. Physical, Cognitive) which you feel would assist our employee in a safe and timely return to work.

_____

_____

_____

PART 5 – Health Care Practitioner Information

Health Care Practitioner Signature:	Date Completed: _____ dd/mm/yyyy
Health Care Practitioner Name and Address:	

PLEASE RETURN THE COMPLETED FORM TO HUMAN RESOURCE SERVICES
CONFIDENTIAL FAX # (705) 748-9563 CONFIDENTIAL EMAIL: HRFax@pvnccdsb.on.ca
Wellness Coordinator – Phone 705-748-4861 ext. 1285