ST. FRANCIS XAVIER UNIVERSITY

ATTENDING PHYSICIAN'S STATEMENT ON EMPLOYEE SICKNESS

YOU MAY MAIL OR FAX THIS FORM DIRECTLY TO:

Human Resources
St. Francis Xavier University
PO Box 5000
Antigonish, NS B2G 2W5
Fax: 902-867-3345

I hereby authorize the release to my employer of any information requested on this form.

Name of Patient (please print): ____

Signature of Patient: ___________________________________ Date: _______________________

The purpose of completing this form is to assist in the *safe and timely return to work* process for the employee.

The patient is responsible for the securing of this form and returning it to his/her supervisor in order to obtain university sick pay and/or leave. Any claim may be unnecessarily delayed if this certification is not properly submitted.

TO PHYSICIANS: PLEASE NOTE

This form may be mailed directly to the university or given to the patient at the physician's discretion.

1. On what date did the illness begin? ____

		YES	NO
2.	Was this patient treated for an infectious disease?	☐	☐
3.	Is the patient now free from infection and able to return to work?	☐	☐
4.	Is the patient suffering from a chronic or recurring problem?	☐	☐
5.	Are there any limitations on his/her ability to perform regular job/duties?	☐	☐

6. Please comment on any physical limitations arising from this condition, including such activities as:

Lifting ____

Walking ____

Standing ____

Kneeling ____

Sitting ____

Repetitive Movements ____

Carrying ____

7. Please outline any cognitive or psychiatric limitations arising from this condition as they relate to activities such as the following that the employer should be aware.

Understanding and memory ____

Sustained concentration ____

Social interaction ____

Ability to work to deadlines ____

Ability to accommodate change ____

8. When will the patient be able to return to work? ________________________________

9. Additional information on the patient's condition or medical circumstances which might affect the duration of this incapacity.

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FOR HOSPITAL STAY EMPLOYEES ONLY

	DD	MM	YY
1. Date of First Visit			
2. Additional Visit(s)			
3. Hospitalized			
4. Surgery			
** **PATIENT HAS BEEN UNBLE TO WORK SINCE**			
** **PATIENT IS EXPECTED TO RETURN TO WORK**			

Name of Physician: ____

Address of Physician: ____

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Telephone Number: ___________________________ Date: _________________________

Signature of Physician: ____