

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)

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: _____