

KELOWNA AND DISTRICT SOCIETY FOR COMMUNITY LIVING

CERTIFICATE OF HEALTH

This form must be completed by your attending physician and returned to your supervisor prior to returning to your normal duties.

This section is to be completed by the supervisor.

Employee's name: _____

Job title: _____

This section is to be completed by your attending physician.

1. How long have you known this person? _____

2. Nature of illness/disability: _____

3. Date of initial examination for current illness/disability: _____

4. In your medical opinion, is the above-noted employee able to perform the full scope of his/her normal duties and job requirements as outline in the attached job description?

No (proceed to #5)

Yes (proceed to #6)

5. (a) If the employee is unable to perform the full scope of his/her normal duties, please explain why: _____

6. What has enabled the employee to perform his/her duties versus at the onset of illness? _____

Name of physician: _____

Telephone: _____

Address: _____

Signature: _____ Date: _____