Third Party Requested Medical Certificate

This form provides information to patients and their employers to assist both parties in making decisions about a patient's readiness to return to work after an illness or non-work related injury.

Patient's Name _____ **Physician's Name** _____

Patient Consent I authorize the attending physician to provide the information requested on this form to my employer or _____ who may use it for the purpose explained to me by my employer or the requesting third party

Patient's Signature _____ **Date** _____

Medical Certificate

This patient is medically able to work as of _____

- □ with no restrictions or limitations
- □ with the restrictions and limitations as noted on the back

The patient is unable to return to work as of _____. See explanation in the comments.

Date of first appointment for current illness/non-work related injury _____

Date of follow-up appointment if necessary _____

Additional Comments

Physician's Signature _____ **Date** _____

Patient to Complete as Required by Employer

Employee Number Supervisor Position
Work location

Completion of this form is an uninsured medical service. There may be a fee charged to the patient or third party for completion of this form. The Third Party Requested Medical Certificate form has been approved by the Newfoundland and Labrador Medical Association for use by physicians. The information included on this form is disclosed in accordance with the *Personal Health Information Act*.

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Functional Assessment

To be completed only if necessary

Restrictions or Limitations are:

□ Permanent

□ Temporary

_____ days	4 to 6 weeks
less than 2 weeks	6 weeks to 2 months
2 to 4 weeks	more than 3 months

Definitions

Restrictions: The patient is advised not to perform this activity in any capacity

Limitation: The patient is able to perform the activity in a reduce capacity, such as without the usual speed, strength or number of repetitions, or for the usual duration.

Provide details about any restrictions or limitations

Physical

Such as: Sitting, Standing, Walking, Lifting, Carrying. Pushing/ Pulling, Climbing Stairs, Crouching, Crawling, Kneeling, Bending/ Twisting, Repetitive activity, Sustained postures, Gripping, Reaching, Fine Dexterity, Balance, Vision/ Hearing/ Speech

Mental

Such as: Thinking, Concentration, Memory, Critical Decision- making, Alertness, Interpersonal Contact

Environmental

Such as: Exposure to heat/ cold, Exposure to dust/fumes/odor, Handling food, Exposure to chemicals

Other

Such as: Shift/attendance duration, Consecutive shifts, Shift work, Operating vehicles, Overtime, Operating equipment

Patient requires medical aids (e.g. splints, braces, mask). Yes No

Physician's Signature _____ **Date** _____

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