DOCTOR'S CERTIFICATE
SICK LEAVE FORM — STAFF & FACULTY

PLEASE NOTE: All costs for the completion of this form are the responsibility of the employee.

UNIVERSITY OF THE FRASER VALLEY
EMPLOYEE SERVICES

1. TO BE COMPLETED BY THE EMPLOYEE (ensure you have informed your supervisor of your absence)

EMPLOYEE'S FULL NAME: (first, last, initial)			EMPLOYEE NUMBER:
BIRTHDATE: (dd/mm/yyyy)	DEPARTMENT:	JOB TITLE:	START DATE OF CURRENT ABSENCE: (dd/mm/yyyy):
EMPLOYEE'S FULL ADDRESS: (number, street and apartment, P.O Box number)		CITY:	POSTAL CODE:
HOME PHONE NO:			

I authorize my health care provider(s) to exchange non-diagnostic information regarding my current illness/injury to assist with my rehabilitative and return to work planning with Human Resources to be maintained in a secure and confidential manner. This authorization is valid for six months.

EMPLOYEE'S SIGNATURE: _____ DATE SIGNED (dd/mm/yyyy): _____

2. TO BE COMPLETED BY ATTENDING PHYSICIAN AND RETURNED TO HUMAN RESOURCES

University of the Fraser Valley
c/o Human Resources
33844 King Road
Abbotsford, BC V2S 7M8

PHONE NO: (604) 854-4554
FAX NO: (604) 854-1538
EMAIL: hrinfo@ufv.ca

EXAMINATION DATE:	Is it your medical opinion the employee is unable to work due to illness or injury? ❑ Yes ❑ No	Has the same illness caused a previous absence in the last three weeks? ❑ Yes ❑ No	Anticipated length of absence: ❑ Less than two weeks ❑ Less than one month ❑ Between one –two months ❑ Other – *specify*:
Have you recommended a treatment program for your patient? ❑ Yes ❑ No	Is your patient following this treatment program? ❑ Yes ❑ No	Is this a WCB claim? ❑ Yes ❑ No	Is this an ICBC claim? ❑ Yes ❑ No
Date cleared to perform full duties with no modifications: (dd/mm/yyyy)			Date cleared for modified duties: (dd/mm/yyyy)

Please indicate your patient's physical or other limitations, if any.
(Please do not include a diagnosis). _____

DURATION OF RESTRICTIONS: _____

RESTRICTIONS ARE: ❑ TEMPORARY ❑ PERMANENT

Next evaluation date: (dd/mm/yyyy)	I have discussed the above with my patient ❑ Yes ❑ No
PHYSICIAN'S FULL ADDRESS: (number, street, city, postal code)	PHYSICIAN'S SIGNATURE: _____ DATE SIGNED (dd/mm/yyyy) : _____
PHYSICIAN'S PHONE NO:	PHYSICIAN'S FAX NO: