Health PEI
One Island Health System

Medical Certificate

Santé Î.-P.-É.
Un système de santé unique

SECTION 1: (To be completed by Employee)	
Employee Name:	Employee Number:
Worksite:	Primary Phone #:
Email Address:	Secondary #
Employee: I authorize my Healthcare provider to disclose functional information (abilities, limitations and restrictions) related to my work. The employer will keep this information confidential	

Employee's Signature _____   Date: _____

SECTION 2: (To be completed by Authorized Health Professional)
Does the Employee have restrictions that prohibits them from fulfilling the responsibilities of their job?   ☐   No, able to remain at full duties   ☐   Yes   Health PEI is committed to the prevention of work disability. Please indicate all specific physical/cognitive functional restrictions here: *(e.g., unable to interact with public, requires a wheelchair-accessible workstation, etc.)* This information will be used to identify suitable temporary or permanent accommodated work   _____   _____   _____
Are these restrictions: ☐   Temporary   ☐   Permanent
These restrictions will be re-evaluated at our next assessment, scheduled _____
Is there any medical contraindication to this employee returning to modified or alternate work?   ☐   No   ☐   Yes   If yes, please explain: _____   _____   _____   _____
Please select the option that best describes the length of time you expect the employee will be unable to perform the full duties of their current role. *Your answer here does not affect their employment status, but allows us to plan for quality service delivery in their absence.*   ☐   Less than 8 weeks   ☐   8 weeks to 3 months   ☐   3 to 6 months   ☐   Greater than 6 months   ☐   I do not anticipate a return to this job

Optional: Are you aware of any workplace barriers that we can address to support the employee in staying at/returning to work? Please indicate here:

_____

Health Care Provider: The information provided in this document is true and based on my assessment of the patient	
Name (Please Print):	Mailing Address:
Telephone:	Fax:

Signature: _____   Date:_____

In order to support our employee in a safe and successful return to work, we ask that you complete this form and ensure it is returned to their manager no later than _____