BCIT®

DOCTOR'S CERTIFICATE

Short Term Illness and Injury Plan
(For BCGEU Employees)

CLEAR FORM

PLEASE NOTE: All costs for the completion of this form are the responsibility of BCIT. Please forward your invoice with this certificate in accordance with the BCMA guidelines. Item No. A00060

A. TO BE COMPLETED FULLY BY EMPLOYEE—*Please type or print*

EMPLOYEE'S LAST NAME | FIRST NAME AND MIDDLE INITIAL | EMPLOYEE NO. | BIRTH DATE YYYY MM DD

EMPLOYEE'S HOME ADDRESS | POSTAL CODE | HOME PHONE NO.

DEPARTMENT | JOB TITLE/CLASSIFICATION | START DATE OF CURRENT ABSENCE YYYY MM DD

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 the Human Resources Department to be maintained in a secure and confidential manner. This authorization is valid for six months.

EMPLOYEE'S SIGNATURE ☒ | DATE SIGNED YYYY MM DD

EMPLOYER'S CONTACT NAME | LOCATION | CONTACT PHONE

B. TO BE COMPLETED BY ATTENDING PHYSICIAN AND RETURNED TO HUMAN RESOURCES—*Please type or print*

British Columbia Institute of Technology
c/o Human Resources
3700 Willingdon Avenue
Burnaby, B.C. V5G 3H2

PHONE NO.: (604) 432-8384
FAX NO.: (604) 434-8462

EXAMINATION DATE YYYY MM DD

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 ☐ BETWEEN ONE—TWO MONTHS ☐ LESS THAN ONE MONTH ☐ 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: *(TICK IF YES)* ☐ WCB CLAIM ☐ ICBC CLAIM

Date cleared to perform full duties with no modifications YYYY MM DD

Date cleared for modified duties/schedule YYYY MM DD

Indicate patient's physical or other limitations, if any—not diagnosis

If patient is ready to return to work, indicate recommended employment modifications , if any

MODIFICATIONS ARE
☐ TEMPORARY
☐ PERMANENT

Next evaluation Date YYYY MM DD

I have discussed the above information with my patient ☐ YES ☐ NO

PHYSICIAN'S ADDRESS | POSTAL CODE | PHYSICIAN'S FAX NO.

PHYSICIAN'S NAME | PHYSICIAN'S SIGNATURE ☒ , M.D | DATE SIGNED YYYY MM DD | PHYSICIAN'S PHONE NO.

Should additional space be required, please use the back of this form.