UNIVERSITÉ D'OTTAWA • UNIVERSITY OF OTTAWA

CONFIDENTIAL -Medical Certificate

EMPLOYEE NUMBER

EMPLOYEE NAME	TELEPHONE NUMBER	DATE OF BIRTH
		YEAR / MONTH / DAY
FACULTY / SERVICE	SUPERVISOR	

1

Is the disability due to sickness or an injury arising from the patient's work? ○ YES ○ NO ○ UNKNOWN

If disability is from accident at work when did the symptoms first appear? YEAR / MONTH / DAY

2

Date of the first visit for present period of illness: YEAR / MONTH / DAY

Next date of follow up visit if applicable: YEAR / MONTH / DAY

Has the patient had the same condition in the last 30 days? ○ YES ○ NO

3

To the best of your knowledge, the patient was/is totally disabled (unable to perform any type of work and pursue studies) from YEAR / MONTH / DAY to YEAR / MONTH / DAY

4

Admission to hospital (if applicable): YEAR / MONTH / DAY

Discharge from hospital (if applicable): YEAR / MONTH / DAY

5

Is this a complication related to pregnancy? ○ YES ○ NO

What is or was the expected date of delivery? YEAR / MONTH / DAY

Details:

6

To the best of your knowledge, this patient will be able to return to work on YEAR / MONTH / DAY ○ FULL TIME ○ PART-TIME

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Human Resources — Health and Wellness
550 Cumberland Street, Room 017, Ottawa (Ontario), Canada, K1N 6N5
Telephone Number: 613-562-5800 ext. 1473 • Fax Number: 613-562-5120
virtuo.uottawa.ca/en/human-resources/health-wellness

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7

The University of Ottawa offers a transitional work program to accommodate employees who require modified duties and/or work hours. What are the patient's current functional limitations that would affect the patient`s ability to work?

LIGHT	MODERATE	SEVERE
Can probably perform the duties of the position, but performance is slightly affected, mild deficit and minimal symptoms.	**Requires moderate support or few accommodations to perform the duties of the position.**	**Significant inability to perform the duties of the position, e.g., unable to perform certain tasks.**

PHYSICAL FUNCTIONAL LIMITATIONS

Walking	☐ NO LIMITATIONS	_____	m
Standing	☐ NO LIMITATIONS	_____	min
Sitting	☐ NO LIMITATIONS	_____	min
Lifting	☐ NO LIMITATIONS	_____	kg
Pushing / pulling	☐ NO LIMITATIONS	_____	kg
Stair climbing	☐ NO LIMITATIONS	_____	steps

Other (Specify) : _____

COGNITIVE FUNCTIONAL LIMITATIONS

Supervision of others	○ LIGHT	○ MODERATE	○ SEVERE
Concentration	○ LIGHT	○ MODERATE	○ SEVERE
Memory	○ LIGHT	○ MODERATE	○ SEVERE
Responsability and accountability	○ LIGHT	○ MODERATE	○ SEVERE
Thinking and reasoning	○ LIGHT	○ MODERATE	○ SEVERE
Deadline pressures	○ LIGHT	○ MODERATE	○ SEVERE

Other (Specify) : _____

Is there a treatment plan in place to address these limitations?

○ YES ○ NO

If NO, please explain.

The above functional limitations will be in place until: YEAR ____ MONTH ____ DAY ____

8

Comments:

NAME OF HEALTH CARE PROVIDER

ADDRESS

SIGNATURE (HEALTH CARE PROVIDER)

DATE YEAR ____ MONTH ____ DAY ____

By submitting this form to Health & Wellness, the employee certifies that the above statements are true and consents to the collection, use or disclosure of this information by the Health & Wellness Sector of the University of Ottawa for the purpose of accommodation & sick leave.

Employee Initials _____

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