



Annapolis Valley

Regional Centre for Education

MEDICAL INFORMATION

Director of Human Resources
Annapolis Valley Regional Centre for Education
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The Annapolis Valley Regional Centre for Education has developed a return to work policy to assist employees in their rehabilitation and return to full health and employment. Part of the process is to get information about your current abilities from your physician as it relates to your illness/injury. To do this we ask that you have your physician complete this form.

Section 1 (To be completed by EMPLOYEE)	
Employee's Name:	Employee Number:
Address:	Telephone (Home):
School/Site:	Telephone (Work):
Immediate Supervisor:	Telephone (Work):
EMPLOYEE: I authorize my Healthcare provider to disclose information related to my current illness or injury to my Employer for the purpose of developing a safe return to work plan. The Employer will keep this information confidential. It is understood that this information shall only be of the same nature and extent as disclosed in Section 2 of this Form and the attached Physical Capability Assessment Form, and does not authorize the release of information which is different in nature or greater in extent. I understand that I will receive a copy of any medical information received by the Board from my physician and will be made aware of any further requests for medical information from the Centre.	
Employee's Signature:	Date:
Section 2 (To be completed by Physician or Authorized Health Professional)	
Does Employee have any impairment that currently impairs the employee from returning to unrestricted duties?	
<input type="checkbox"/> NO Employee can return to unrestricted work activities. <input type="checkbox"/> YES If yes, please answer the following questions:	
If the employee currently has a physical impairment, please complete the Physical Capability Assessment (on reverse side). If the impairment is non physical, please describe the current limitations the employer should bear in mind. PLEASE DO NOT INCLUDE A DIAGNOSIS.	
Is the physical or psychological impairment: <input type="checkbox"/> Temporary <input type="checkbox"/> Permanent <input type="checkbox"/> Unknown at this time	If the impairment is temporary, how long do you think the impairment will last? <input type="checkbox"/> 2-4 weeks <input type="checkbox"/> 4-6 weeks <input type="checkbox"/> 6-8 weeks <input type="checkbox"/> >3 mos.
Expected date of return to regular duties of work?	
When is the employee scheduled for a reassessment?	
(Optional) Are there workplace barriers or steps that the Employer could take to assist in recovery and rehabilitation?	
Health Care Provider: The information provided in this document is true and based on my examination of the patient.	
Signature:	Date:
Name (Print):	
Mailing Address:	
Telephone Number:	Fax Number:



Employee Name: _____

LIFTING	No Restriction	Occasional	Restricted
Sedentary			
Light			
Medium			
Heavy			

STANDING	No Restriction	Occasional	Restricted
1 hr – 2 hr			
2 hr – 4 hr			
4 hr – 6 hr			
6 hr – 8 hr			

CARRYING	No Restriction	Occasional	Restricted
Sedentary			
Light			
Medium			
Heavy			

WALKING	No Restriction	Occasional	Restricted
1 hr – 2 hr			
2 hr - 4 hr			
4 hr – 6 hr			
6 hr – 8 hr			

BENDING	No Restriction	Occasional	Restricted
To a desk			
To the floor			

L ARM USE	No Restriction	Occasional	Restricted
Above Shoulder			
Below Shoulder			

CLIMBING	No Restriction	Occasional	Restricted
Stairs			
Ladders			

R ARM USE	No Restriction	Occasional	Restricted
Above Shoulder			
Below Shoulder			

SITTING	No Restriction	Occasional	Restricted
1 hr – 2 hr			
2 hr – 4 hr			
6 hr – 8 hr			

L HAND USE	No Restriction	Occasional	Restricted
General Tasks			
Fine Control			
Gripping			

SHOULDER MOVEMENT	No Restriction	Occasional	Restricted
1 hr – 2 hr			
2 hr – 4 hr			
6 hr – 8 hr			

R HAND USE	No Restriction	Occasional	Restricted
General Tasks			
Fine Control			
Gripping			

VOICE	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Occasional Difficulty	<input type="checkbox"/> Constant Difficulty
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HEARING	<input type="checkbox"/> No Difficulty	<input type="checkbox"/> Occasional Difficulty	<input type="checkbox"/> Constant Difficulty
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Health Care Provider: The information provided in this document is true and based on my examination of the patient.

Signature:	Date:
Professional Designation:	
Mailing Address:	
Telephone Number:	Fax Number: