



OECTA Medical Certificate



Part 1 – Employee please complete:

(Employee name – please print)

Absent from Work since _____
(first date of absence)

Not absent from Work, but requires accommodation

The information supplied will be used in a confidential manner and may assist in creating a return to work plan.

I hereby consent to the completion of this form by:

(Treating Medical Practitioner's Name)

(Signature of Employee)

(Date)

Part 2 – Medical Practitioner please complete:

1. Nature of Illness (do not provide diagnosis):

**"Nature of the illness" (or injury) suggests a general statement of a person's illness or injury in plain language, without any technical medical details including diagnosis or symptoms. Although revealing the nature of an illness may suggest the diagnosis, it will not necessarily do so. "Nature of illness" and "diagnosis" are not congruent terms. For example, a statement that a person has a cardiac or abdominal condition, or that s/he has undergone surgery in that respect reveals the essence of the situation without revealing a diagnosis.*

2. Is this condition the result of (check one): non-occupational illness/injury occupational illness/injury

3. Is he/she receiving treatment: Yes No

4. Has, or will, a referral to a specialist been made? Yes (if yes, date of referral _____) No

5. Have you discussed return to work with your patient? Yes Not at this time

6. Is the patient able to return to work:

without accommodation with accommodation unable to return to work at this time

Expected date of return: _____

7. Date of next assessment: _____

Part 3 and/or 4 need only be completed for a return to work that requires an accommodation.

Part 5 below is to be completed.

Cognitive Restrictions and/or Limitations



Part 3 – Medical Practitioner please complete or check if this form is Not Applicable

Please describe cognitive limitations and/or restrictions. Physical limitations and/or restrictions can be detailed in Part 4. The limitations/restrictions will be assessed when determining modified work, either in the employee's own position or another suitable position.

Name of employee: _____ Date of Assessment: _____

<u>Level of Functioning</u> (Please circle which level applies for each task)	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Supervision Required	needs constant supervision	needs frequent supervision	needs limited supervision	requires no supervision
Supervision of Others	not able to supervise others	can meet demands of or for occasional supervision	can meet demands of or for regular supervision	can meet demands of full supervision
Tolerance to Deadlines	cannot deal with deadline pressures	occasionally deal with deadlines	can deal with deadlines that are reoccurring	can deal with strict deadlines
Attention to Detail (indicate maximum time the Individual can concentrate)	concentration on detail is severely limited	concentrate on detail is limited	can concentrate on details, needs occasional breaks of non detailed work	able to concentrate intensely on detailed work
Performance of Multiple Tasks	can deal with one task at a time	can handle more than 1 task but requires cues as to when to do task	can handle multiple tasks requires some time mgmt assistance	fully able to handle multiple tasks without difficulty
Tolerance to External Stimulus	needs quiet, non distracting work environment	can cope with small degree of distraction	can cope with distracting stimuli for portion of day	fully able to cope with multiple stimuli without negative effect
Ability to Work with Others Cooperatively	tolerates working alone	can tolerate others within vicinity, but needs to perform independent tasks	can work with others cooperatively when required	fully able to work in close cooperation with others
Confrontational Situations	unable to cope with confrontational situations	can cope with exposure to confrontational situations with back-up available	moderate ability to cope with confrontational situations	able to deal with confrontational situations with tact and control
Responsibility and Accountability	errors in judgment or attention likely to occur	can exercise a moderate level of responsibility with occasional need for support	can accept responsibility including the responsibility for the safety of others	can accept a high level of responsibility including sensitive situations

Prognosis (based on objective assessments) **from the date of this assessment, the above will apply for approximately:**

1-2 weeks 3-5 weeks 6-8 weeks 2-3 months 4-6 months 6+ months Unknown

Recommendations for work hours and start date:

Regular full time hours Modified hours Graduated hours Start Date: _____

Next appointment date to review limitations and/or restrictions: _____

Please provide any additional information/comments/findings/limitations which you feel would assist our employee in a safe and timely return to work

Physical Restrictions and/or Limitations



Part 4 – Medical Practitioner please complete or check if this form is Not Applicable

Please describe Physical limitations and/or restrictions. Cognitive limitations and/or restrictions can be detailed in Part 3. The limitations/restrictions will be assessed when determining modified work, either in the employee's own position or another suitable position.

Name of employee: _____

Date of Assessment: _____

Walking: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 100 metres <input type="checkbox"/> 100 - 200 metres <input type="checkbox"/> Other (please specify) _____		Standing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15 - 30 minutes <input type="checkbox"/> Other (please specify) _____		Sitting: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 30 minutes <input type="checkbox"/> 30 minutes - 1 hour <input type="checkbox"/> Other (please specify) _____		Lifting from floor to waist: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (please specify) _____	
Lifting from Waist to Shoulder: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other (please specify) _____		Stair Climbing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 steps <input type="checkbox"/> 5 - 10 steps <input type="checkbox"/> Other (please specify) _____					
<input type="checkbox"/> Bending/twisting repetitive movement of (please specify): _____		<input type="checkbox"/> Work at or above shoulder activity: _____		Limited pushing/pulling with: Left Arm <input type="checkbox"/> Right Arm <input type="checkbox"/> Other (please specify) _____		<input type="checkbox"/> Limited use of hand(s): Left <input type="checkbox"/> Right <input type="checkbox"/> <input type="checkbox"/> Gripping <input type="checkbox"/> <input type="checkbox"/> Pinching <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/>	
<input type="checkbox"/> Operating motorized Equipment		<input type="checkbox"/> Environmental Exposure to: (heat, cold, noise)		<input type="checkbox"/> Chemical exposure to: _____		<input type="checkbox"/> Exposure to Vibration: <input type="checkbox"/> Whole body <input type="checkbox"/> Hand/arm	
Other (Please describe) _____							

Prognosis (based on objective assessments) **from the date of this assessment, the above will apply for approximately:**

- 1-2 weeks
 3-5 weeks
 6-8 weeks
 2-3 months
 4-6 months
 6+ months
 Unknown

Recommendations for work hours and start date:

- Regular full time hours
 Modified hours
 Graduated hours
 Start Date: _____

Next appointment date to review limitations and/or restrictions: _____

Please provide any additional information/comments/findings/limitations which you feel would assist our employee in a safe and timely return to work.

Health Care Practitioner Information



Part 5 – Health Care Practitioner Information

Medical Practitioner Name:	Date completed:
Health Care Practitioner Name and Address:	