



MEDICAL CERTIFICATE

REQUEST FOR EXTENDED or PARTIAL MEDICAL LEAVE

The information in this report is considered confidential.

Please note: Any costs incurred for completion of this form is the patient's responsibility.

A. To Be Fully Completed by Employee			
Employee's Surname: _____ Given Names: _____			
Work Location	Position	Start Date of Current Absence	_____
		(D/M/Y)	
I authorize my health care provider(s) to complete this Physician's Statement and to release this Medical Certificate to my Employer.			
_____ Employee Signature		_____ Date Signed (D/M/Y)	
B. Physician's Statement: To Be Fully Completed by Attending Physician			
Examination Date	Has this individual been referred to a medical specialist?	I anticipate that this individual will be able to return to their full work assignment on:	
_____ (D/M/Y)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ (D/M/Y)	
Have you recommended a treatment program for your patient?	Is your patient following this treatment program?	Please indicate if this claim is either of the following:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> WorkSafe BC <input type="checkbox"/> ICBC	
I certify that the above-named individual requires a medical leave due to:			
In the case of a partial leave request, are there ways to address the medical cause other than a reduced workload? If yes, please elaborate.			
This illness will prevent this employee from working because:			
When this employee returns to work I anticipate the following restrictions: (please include duty restrictions, maximum hours per day and estimated length of gradual return to work)			
What medical follow-ups, if any, are occurring related to this illness/injury?			
<i>For information purposes only: Please be aware of the availability of Employee and Family Assistance Program (EFAP)</i>			
I have discussed the above information with my patient <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physician's Name	Physician's Signature	Date Signed	Physician Tel. No.
		_____ (D/M/Y)	
Physician's Address			Physician Fax No.

Please return this form to the Gulf Islands School District:

Attention: Adrian Pendergast, District Principal, Human Resources. Fax/Email address: 250.537.4200 / apendergast@sd64.org

November 4, 2025