SCHOOL DISTRICT NO. 85 (VANCOUVER ISLAND NORTH)
P.O. Box 90
Port Hardy, B.C. VON 2PO
(250) 949-6618
Fax (250) 949-8792

VERIFICATION OF MEDICAL STATUS
For Employees Wishing to Return to Work

_____ has been examined or is under treatment by me
(Employee's name)

and I advise that, in my opinion, this person will be physically and mentally fit to return to normal duties as of _____20_____ subject to the following conditions:
(Date)

_____

_____

_____

_____
(Doctor's signature)

_____
(Office address)

_____
(Office telephone number)

_____20 _____
(Date)

If there is a cost for this service please invoice the Board at the address above.

❑ RETURN TO WORK PHYSICAL ASSESSMENT REPORT

Employee: _____ Date: _____

Name of attending physician _____
(Please print)

Physical Limitations of injured worker:

Walking ❑ **Without Restriction**
❑ Some Restriction
❑ No Walking

Standing ❑ **Without Restriction**
❑ Some Restriction
❑ No Standing

Stairs ❑ **Without Restriction**
❑ Some Restriction
❑ No Stairs

Ladders ❑ **Without Restriction**
❑ Some Restriction
❑ No Ladders

Lifting ❑ **Without Restriction**
❑ Some Restriction
❑ No Lifting

Carrying ❑ **Without Restriction**
❑ Some Restriction
❑ No Carrying

Sitting ❑ **Without Restriction**
❑ Some Restriction
❑ No Sitting

Bending ❑ **Without Restriction**
❑ Some Restriction
❑ No Bending

Rough Roads ❑ **Without Restriction**
❑ Some Restriction
❑ No Rough Roads

Repetitive Movement (Arms/Wrists) ❑ **Without Restriction**
❑ Some Restriction
❑ No Repetitive Movements

Please specify restrictions (as identified above): _____

_____

_____

Additional comments:

_____

_____

Duration of restriction(s) _____ ❑ day(s) or ❑ week(s)

If alternate duties, which meet the above defined restrictions, are available, is this worker capable of returning to work? ☐ YES ☐ NO

Physician's Signature: _____ Date: _____