

**Attending Medical Professional Statement**

|  |  |
| --- | --- |
| Name of Patient:       | Date Symptoms Appeared:       |
| Position & Responsibilities at Acadia:       |
| Nature of Medical Condition interfering with Patient’s Work:       |
| Nature of Treatment:       |
| Is the Patient able to perform their work duties? :  |  [ ]  Full-time [ ]  Part-Time [ ]  No |
| **Prognosis** |
| Do you expect the patient to recover sufficiently to perform their normal duties on a full-time basis?[ ]  Yes [ ]  No When?       |
| If the answer to the above question is ‘no’, could the patient return to their work responsibilities on a part-time basis?[ ]  Yes [ ]  No When?       |
| Is there an accommodation needed to enable the patient to perform their work duties?[ ]  Yes [ ]  No When?      Please describe:       |
| Is there anything else the employer should be aware of or should be doing?       |
| Medical Professional:       | Date:       |
| Contact Numbers:       |
| Email:       |

 **TO BE COMPLETED BY EMPLOYEE:** By signing below, I consent to the disclosure of the medical information contained in this document and any records or documents attached thereto by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (medical prof). I understand that more information may be required. In the event this is the case and Human Resources requests more relevant information, I may be asked for additional information.

|  |  |
| --- | --- |
| Employee Signature:  | Date:       |

**Forward this form to the Human Resources Department via email:** **kathy.klein@acadiau.ca**

|  |
| --- |
| **Completed by Human Resources Department** |
| Approved for Sick Leave Benefits: [ ]  Yes [ ]  No | Effect Start Date:  | End Date: |
| Comments: |
| Authorized Signature: | Date: |