

**Attending Medical Professional Statement**

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| 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.

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

**Forward this form to the Human Resources Department via email:** [**kerry.deveau@acadiau.ca**](mailto:kerry.deveau@acadiau.ca)

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