

**Attending Physician’s Statement   
of Illness or Disability**

**New Hire Information Form**

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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: | Ambulatory  Confined to Bed in Hospital  Confined to Bed at Home | |
| **Prognosis** | | |
| Do you expect the patient to recover sufficiently to perform his/her normal duties on a full-time basis?  Yes  No When? | | |
| Could the patient return to his/her work responsibilities on a part-time basis?  Yes  No When? | | |
| If the answer to the above two questions is “no”, do you expect the patient to recover sufficiently to perform different or less strenuous duties?  Yes  No When?  Please describe: | | |
| Is there anything else the employer should be aware of or should be doing? | | |
| Attending Physician: | | Date: |
| Contact Numbers: | | |
| Email: | | |

**TO BE COMPLETED BY EMPLOYEE:** I give my permission for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release information regarding my health to the Human Resources Department at Acadia University.

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

**Forward this form to the Human Resources Department via:   
Email:** [**kerry.deveau@acadiau.ca**](mailto:kerry.deveau@acadiau.ca) **or Fax: 902-585-1075**

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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: | |