

**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** **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: |