



# DOCTOR'S CERTIFICATE

Short Term Illness and Injury Plan  
(For BCGEU Employees)

PLEASE NOTE: All costs for the completion of this form are the responsibility of BCIT. Please forward your invoice with this certificate in accordance with the BCMA guidelines.

**A. TO BE COMPLETED FULLY BY EMPLOYEE—Please type or print**

EMPLOYEE'S LAST NAME		FIRST NAME AND MIDDLE INITIAL		EMPLOYEE NO.		BIRTH DATE YYYY MM DD	
EMPLOYEE'S HOME ADDRESS				POSTAL CODE		HOME PHONE NO.	
DEPARTMENT		JOB TITLE/CLASSIFICATION		START DATE OF CURRENT ABSENCE		YYYY MM DD	
I authorize my health-care provider(s) to exchange non-diagnostic information regarding my current illness/injury to assist with my rehabilitative and return to work planning with the Human Resources Department to be maintained in a secure and confidential manner. This authorization is valid for six months.				EMPLOYEE'S SIGNATURE  <input checked="" type="checkbox"/>		DATE SIGNED YYYY MM DD	
EMPLOYER'S CONTACT NAME		LOCATION		CONTACT PHONE			

**B. TO BE COMPLETED BY ATTENDING PHYSICIAN AND RETURNED TO HUMAN RESOURCES—Please type or print**

British Columbia Institute of Technology  
c/o Human Resources  
3700 Willingdon Avenue  
Burnaby, B.C. V5G 3H2

**PHONE NO.: (604) 432-8384**  
**FAX NO.: (604) 434-8462**

EXAMINATION DATE YYYY MM DD	Is it your medical opinion the employee is unable to work due to illness or injury? <input type="checkbox"/> YES <input type="checkbox"/> NO	Has the same illness caused a previous absence in the last three weeks? <input type="checkbox"/> YES <input type="checkbox"/> NO	Anticipated length of absence <input type="checkbox"/> LESS THAN TWO WEEKS <input type="checkbox"/> LESS THAN ONE MONTH	<input type="checkbox"/> BETWEEN ONE-TWO MONTHS <input type="checkbox"/> OTHER—specify:
Have you recommended a treatment program for your patient? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is your patient following this treatment program? <input type="checkbox"/> YES <input type="checkbox"/> NO	Is this a: (TICK IF YES) <input type="checkbox"/> WCB CLAIM <input type="checkbox"/> ICBC CLAIM		
Date cleared to perform full duties with no modifications YYYY MM DD	Date cleared for modified duties/schedule YYYY MM DD			

Indicate patient's physical or other limitations, if any—not diagnosis

If patient is ready to return to work, indicate recommended employment modifications, if any

		MODIFICATIONS ARE <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PERMANENT	
Next evaluation Date YYYY MM DD	I have discussed the above information with my patient <input type="checkbox"/> YES <input type="checkbox"/> NO		
PHYSICIAN'S ADDRESS		POSTAL CODE	PHYSICIAN'S FAX NO.
PHYSICIAN'S NAME	PHYSICIAN'S SIGNATURE  <input checked="" type="checkbox"/> , M.D.	DATE SIGNED YYYY MM DD	PHYSICIAN'S PHONE NO.

Should additional space be required, please use the back of this form.