

**SCHOOL DISTRICT NO. 85 (VANCOUVER ISLAND NORTH)**  
**P.O. Box 90**  
**Port Hardy, B.C. VON 2P0**  
**(250) 949-6618**  
**Fax (250) 949-8792**

VERIFICATION OF MEDICAL STATUS  
For Employees Wishing to Return to Work

\_\_\_\_\_ has been examined or is under treatment by me  
(Employee's name)

and I advise that, in my opinion, this person will be physically and mentally fit to return  
to normal duties as of \_\_\_\_\_ 20\_\_\_\_ subject to the following conditions:  
(Date)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(Doctor's signature)

\_\_\_\_\_  
(Office address)

\_\_\_\_\_  
(Office telephone number)

\_\_\_\_\_ 20 \_\_\_\_  
(Date)

If there is a cost for this service please invoice the Board at the address above.

\_\_\_\_\_

**RETURN TO WORK PHYSICAL ASSESSMENT REPORT**

Employee: \_\_\_\_\_ Date: \_\_\_\_\_

Name of attending physician \_\_\_\_\_  
(Please print)

Physical Limitations of injured worker:

**Walking**       **Without Restriction**      **Standing**       **Without Restriction**  
 Some Restriction       Some Restriction  
 No Walking       No Standing

**Stairs**       **Without Restriction**      **Ladders**       **Without Restriction**  
 Some Restriction       Some Restriction  
 No Stairs       No Ladders

**Lifting**       **Without Restriction**      **Carrying**       **Without Restriction**  
 Some Restriction       Some Restriction  
 No Lifting       No Carrying

**Sitting**       **Without Restriction**      **Bending**       **Without Restriction**  
 Some Restriction       Some Restriction  
 No Sitting       No Bending

**Rough Roads**       **Without Restriction**      **Repetitive**       **Without Restriction**  
 Some Restriction       Some Restriction  
 No Rough Roads       No Repetitive Movements  
Movement (Arms/Wrists)

Please specify restrictions (as identified above): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Additional comments:

\_\_\_\_\_  
\_\_\_\_\_

Duration of restriction(s) \_\_\_\_\_  day(s) or  week(s)

If alternate duties, which meet the above defined restrictions, are available, is this worker capable of returning to work?       YES       NO

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_