



# Certificate of Illness

**Instructions:** To receive sick leave benefits, for absences of six (6) or more working days, both Section 1 and Section 2 of this form must be completed.

Email completed form to [ehrc@cbe.ab.ca](mailto:ehrc@cbe.ab.ca) or fax to the Employee Health Resource Centre at 403-777-6065.

**Exception:** Employees of Facility Caretaking should fax directly to Facility Caretaking Services at 403-214-1216.

<b>Section 1: Employee Information</b>				<i>To be completed by Employee</i>	
<b>First Name:</b>		<b>Last Name:</b>			
<b>Employee ID:</b>		<b>Location:</b>			
<b>Position:</b>		<b>First Day Off:</b>		<b>Area:</b>	
I hereby voluntarily agree to the release of information on this form to the Calgary Board of Education for the purposes specified below. I am aware of the reasons why the health information is needed and the risks and benefits of consenting or refusing to consent. This consent is effective for the length of this illness absence unless I revoke my consent by notifying the Employee Contact Centre, in writing.					
<b>Signature:</b>				<b>Date:</b>	
If you have questions regarding the use of this form please contact the Employee Contact Centre at 403-817-7333 or your Union/Association.					
<b>Section 2: Medical Practitioner</b>				<i>To be completed by Medical Practitioner</i>	
Does the above named CBE employee have a medical condition/injury, which renders the employee unable to perform his or her work duties? <input type="checkbox"/> Yes <input type="checkbox"/> No Date of disability: _____ (DD/MM/YYYY)					
Is the cause of the illness/injury work related? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is he/she under your care and receiving and participating in all appropriate treatment for that condition? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Expected return to work date: _____ (DD/MM/YYYY) and/or reassessment date: _____ (DD/MM/YYYY)					
If unknown, is the absence likely to be: <input type="checkbox"/> <30 days* <input type="checkbox"/> 30-60* <input type="checkbox"/> 61-90* <input type="checkbox"/> >90 <i>*We understand this is an estimate and may change according to response to treatment.</i>					
Is your patient capable of performing modified work? <input type="checkbox"/> Yes <input type="checkbox"/> No When: _____ (DD/MM/YYYY)					
<b>Note:</b> If your patient requires modified duties or medical accommodation for a return to work please contact the Employee Health Resource Centre for assistance at 403-817-7388.					
<b>Physician Name:</b>				<b>Phone:</b>	
<b>Signature:</b>				<b>Date:</b>	

Personal information is collected under the authority of Alberta's Freedom of Information and Protection of Privacy Act (FOIP). This information will be used for the management of personnel and for the delivery of Human Resources programs at the Calgary Board of Education. It will be treated in accordance with the privacy protection provisions of FOIP. If you have any questions about this collection of personal information, please contact a HR Employee Contact Centre Representative at 403-817-7333 to direct your question.