Telehealth Doctor's Certificate Form Instructions

The telehealth doctor's certificate form can be used for telephone and/or virtual medical appointments during COVID-19, if a doctor's certificate is required.

Please follow the guidelines below to ensure all necessary steps are completed.

For the Employee:

Short Term Illness and Injury leave (STIIP) is a benefit for which you need to apply and qualify for by providing sufficient medical information to your employer to show evidence of medical disability during the benefit period.

1. Open the telehealth doctor's certificate form using Adobe Acrobat Reader. Adobe Acrobat Reader is a free download. You do not need to register an account with Adobe. https://get.adobe.com/reader/
2. Complete Part A.
3. Ensure Part B is signed and dated to indicate your authorization.
   Instructions how to add an electronic signature can be found on MyHR.
4. Once Part A and B are completed, save.
5. Email the form and the instructions to your physician for completion.
6. Once completed by your physician you should obtain a copy of the telehealth doctor's certificate form. If required, provide a copy of the form without the Physician's Confidential Report Section to your supervisor.

Please note: You are not required to provide your confidential diagnostic information to your supervisor.

For the Physician:

Your patient has applied for STIIP benefits and is relying on your assessment and documentation. Your patient has forwarded you the telehealth doctor's certificate form for completion.

1. Complete Part C, **including** the Physician's Confidential Report section.
2. Please write legibly and concisely.
3. Send completed form to Occupational Health and Rehabilitation via fax or mail.
   Fax: 1-877-340-3726
   Mail: 707 – 808 NELSON STREET, BOX 12183, VANCOUVER, BC, V6Z 2H2
4. Send a copy of the completed form to your patient.

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Doctor's Certificate Form **Guidelines**

General

The form is designed to transmit the diagnostic information directly and solely to Occupational Health and Rehabilitation (OHR). Wherever operationally possible, supervisors will identify modified duties that meet the employee's limitations to provide early, safe, modified return to work opportunities.

If supervisors or employees have questions related to the completion of the form, they can contact MyHR. Information on the Short Term Illness and Injury Plan can be found in applicable collective agreements and through MyHR.

Supervisor's Responsibility

Sick leave is subject to a supervisor's approval. The form *may* be used to obtain medical evidence of an employee's inability to work in any of the following circumstances:

1. where the employee has been absent for six consecutive scheduled days of work;
2. on the 3rd (or more) separate absence occurring in a six-month period which may indicate a pattern of concern;
3. where at least 30 days have elapsed since the last statement was obtained and the employee has been in receipt of plan benefits throughout that period and there is reason to believe the employee's prognosis has changed.

Where an employee has provided satisfactory evidence for an absence due to medical disability, it is not appropriate for the supervisor to require further forms other than as detailed in (3) above.

Where the employer requires further information, guidance derived from the form will be obtained from OHR. Release of this information will be consistent with the signed form's authorization. OHR will review all doctor's certificate forms and a clinician will update the supervisor if required.

Following this review, it may be appropriate and reasonable for the supervisor to pose specific questions of the employee's physician. Such questions will be in writing and provided to the physician through the employee.

Employee's Responsibility

Employees are responsible for reporting absences due to injury or illness to their supervisor. Employees are responsible for providing evidence of medical disability through their physician so the supervisor will be able to properly assess whether an employee is unable to work because of illness or injury.

Completion of the employee authorization is necessary for community physicians to complete the form and for OHR to provide non-diagnostic guidance to the supervisor.

Employees will be reimbursed by their work unit or ministry for 50 percent of the cost of the form.

Physician's Responsibility

Part C of the form must clearly state the physical/mental limitations impacting the employee's ability to perform their job. This does not require detailing the actual diagnosis in the upper portion of Part C. It does require detailing the physical/mental limitations and restrictions resulting from that diagnosis. Further information may be required including the expected return to work date (where applicable), and whether a follow-up treatment program is required.

When the doctor's certificate states vague physical concerns, such as "employee is sick" or "employee is unable to work", the supervisor will not be able to make a determination of eligibility for STIIP benefits. Per the CPSBC Medical Certificates Practice Standard, objective statements of the physical/mental limitations and restrictions will greatly assist in facilitating positive outcomes, for example "employee is unable to bend at the knees" in situations where there is a requirement to lift 20 pound boxes or "employee cannot concentrate and is unable to drive" when driving is required as part of the job duties.

PRINT CLEAR FORM

BRITISH COLUMBIA

TELEHEALTH DOCTOR'S CERTIFICATE
For Medical Appointments during COVID-19

Freedom of Information and Protection of Privacy Act (FOIPPA)
This information is collected by the British Columbia Public Service under s. 26(c) of FOIPPA. Any questions about the collection and the use of this information can be directed to an HR Service Representative at the BC Public Service Agency by submitting a request to AskMyHR and selecting My Team/Organization > Employee & Labour Relations > Other Issues & Inquiries, phoning: 1-877-277-0772 or writing to: Manager, Contact Centre Operations, BC Public Service Agency, 810 Blanshard Street, Victoria, BC V8W 2H2.

A. TO BE FULLY COMPLETED BY EMPLOYEE

EMPLOYEE'S LAST NAME	FIRST NAME AND MIDDLE INITIAL	EMPLOYEE ID	BIRTH DATE YYYY MM DD

EMPLOYEE'S HOME ADDRESS (house/apt #, street, city, province, postal code)	EMPLOYEE'S E-MAIL ADDRESS	HOME PHONE NO.

JOB TITLE	JOB CLASSIFICATION	START DATE OF CURRENT ABSENCE YYYY MM DD

MINISTRY/BRANCH NAME	SUPERVISOR'S CONTACT NAME	SUPERVISOR'S CONTACT NO.

B. EMPLOYEE AUTHORIZATION *(Send to your physician upon completion of Section A and providing consent)*

I authorize my health-care provider(s) to exchange confidential information regarding my current illness with Occupational Health and Rehabilitation (doctors, nurses, injury recovery specialists and other health care team members) to be maintained in a secure and confidential manner. I further authorize the release of pertinent non-diagnostic information to assist with my rehabilitation and return-to-work planning. This authorization is valid for six months.

DATE SIGNED YYYY MM DD

Employee Signature (FILL AND SIGN) X

C. TO BE FULLY COMPLETED BY ATTENDING PHYSICIAN – provide objective medical information when responding below

EXAMINATION DATE YYYY MM DD

Has the same illness caused a previous absence in the last three weeks? ☐ YES ☐ NO

Is this a: *(TICK IF YES)* ☐ WSBC CLAIM ☐ IN-PERSON APPOINTMENT

Have you recommended a treatment program for your patient? ☐ YES ☐ NO

Is your patient following this treatment program? ☐ YES ☐ NO

A gradual return to work assists recovery and improves long term medical outcomes. What is the estimated earliest potential return to work (with modified duties/schedule if needed)? YYYY MM DD

Date cleared to perform full duties with no modifications YYYY MM DD

Indicate patient's limitations or restrictions arising from their medical condition(s), if any. Do NOT indicate diagnosis in this section

LIMITATIONS / RESTRICTIONS ARE:

☐ TEMPORARY

☐ PERMANENT

PHYSICIAN'S NAME	PRACTITIONER NUMBER:	PHYSICIAN'S PHONE NO.	PHYSICIAN'S FAX NO.

PHYSICIAN'S ADDRESS	PHYSICIAN'S SIGNATURE	DATE SIGNED YYYY MM DD
	X , M.D.	

Physician's Confidential Report – Completed form is to be sent to Occupational Health and Rehabilitation (OHR) via fax (1-877-340-3726) or mailing address below.

For assistance with occupational medical issues, contact our office at:
Occupational Health and Rehabilitation
707 – 808 NELSON STREET, BOX 12183, VANCOUVER, BC, V6Z 2H2
Phone: 604-660-2587 Fax: **1-877-340-3726** Email: OccupationalHealthPrograms@gov.bc.ca

Provide copy to your patient (contact information noted in Section A above).

PRIMARY DIAGNOSIS AND DIAGNOSTIC CODE	SECONDARY DIAGNOSIS AND DIAGNOSTIC CODE

PROGRESS REPORT OR COMMENTS (If a previous report has been completed for this condition, describe progress and/or complications.)

Describe any workplace health issues for the occupational health doctors or others to review.

I have discussed the above information with my patient ☐ YES ☐ NO