BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

MEDICAL REPORT - EMPLOYABILITY

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance Act*. The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. For any questions concerning the collection, use or disclosure of this information, please contact your local Employment and Assistance Office.

A - PERSONAL IDENTIFICATION

Last Name	First Name	Middle Name
Case Number	Personal Health Number	

B - AUTHORITY TO RELEASE INFORMATION (Completed by Client)

As requested in this form, I consent to the medical practitioner, indicated below, to disclose medical information about me, to the Ministry of Social Development and Poverty Reduction for the purposes of assisting the Ministry to assess employability.

Signature of Client	Date Signed (YYYY MMM DD)	Signature of Witness

C - MEDICAL ASSESSMENT - To be completed by a Medical Practitioner (Please Print)

All questions must be answered completely in order for the Ministry of Social Development and Poverty Reduction to determine how a recipient's medical conditions may affect their employability. Incomplete information will result in the recipient not being adjudicated for the appropriate client category. The contents of this report are confidential, but are subject to the following conditions:

- the report will be shared with the Applicant;
- the report will be shared with the Employment and Assistance Appeal Tribunal if an appeal is initiated.

1. Medical condition:

Date of Onset (YYYY MMM DD)

a. Primary medical condition: ____________ ____________

b. Secondary medical condition(s): ____________ ____________

c. How would you describe the overall medical condition? mild ☐ moderate ☐ severe ☐

2. Prognosis

a. Expected duration of medical condition(s): ☐ expected number of weeks/months ____________ or check appropriate range below:

☐ 1 - 3 mos. ☐ 3 - 6 mos. ☐ 6 - 9 mos. ☐ 9 - 12 mos. ☐ 12 - 18 mos. ☐ 18 - 24 mos.

☐ more than 2 years, additional comments: ____________

b. Medical condition(s) is episodic in nature. ☐ Yes ☐ No

i) How frequently have the episodes occurred? ____________

ii) How frequently are they likely to recur? ____________

3. Restrictions

Please describe the nature of any restrictions specific to the above medical condition(s). (for example, restricted motion in arms or legs)
(attach additional pages if required)

4. Certification

I, ____________ am a physician registered with the College of Physicians and Surgeons of British Columbia and licensed to practice clinical medicine in BC.

☐ I am a general practitioner

☐ I am a specialist in ____________

This report contains my findings and considered opinion at this time. I have been the patient's medical practitioner for:

☐ 6 months or less ☐ Over 6 months If under 6 months

☐ I have examined previous medical records

☐ I have not examined previous medical records

Address including postal code (stamp or print)

Payment:
The fee for completing this form may be billed through MSP on Fee Item 96504. The Ministry rate table is available at www2.gov.bc.ca/gov/content/governments/policies-for-government/bcea-policy-and-procedure-manual/bc-employment-and-assistance-rate-tables/fees-for-health-professionals-and-service-providers-rate-table

Signature of Medical Practitioner	Date Signed (YYYY MMM DD)
Medical Practitioner Number	Telephone

SAMPLE