MEDICAL ABSENCE FORM

STRICTLY CONFIDENTIAL

☐	**COAL MOUNTAIN OPERATIONS**	BOX 3000, SPARWOOD, BC V0B 2G0	**FAX: (250) 425-7371**
☐	**ELKVIEW OPERATIONS**	RR1, HWY 3, SPARWOOD, BC V0B 2G	**FAX: (250) 425-8727**
☐	**FORDING RIVER OPERATIONS**	BOX 100, ELKFORD, BC V0B 1H0	**FAX: (250) 865-5222**
☐	**GREENHILLS OPERATIONS**	BOX 5000, ELKFORD, BC V0B 1H0	**FAX: (250) 865-3230**

Section A: Employee Authorization (*to be completed by Employee)*

I authorize and instruct my attending physician to fully complete the form below regarding my present condition or illness and return it to the Teck Operation identified above. I also authorize the Teck Operation identified above to contact my attending physician in writing, with me copied, for the limited purpose of clarifying the information that is expressly sought by this form. I authorize my attending physician to respond to any such request in writing with a copy sent to me.

To the extent that Teck is simply seeking to discern my physician's handwriting under Part B of this form, I authorize Teck to contact my physician's office to obtain such information and I authorize my physician's office to provide such information.

Employee Name (please print) _____ Payroll Number _____ Employee Signature _____

Section B: Medical Information *(to be completed by attending Physician)*

Date of first visit for this absence:				
Absence Due to:	Non- Occupational:	# Accident	# Illness	# Hospitalization
	Occupational:	# Accident	# Illness	
(In layman's terms) best describe the patient's current prognosis:				
Complications or possible effects of medication (if any) with potential impacts on the workplace, as discussed with the patient, or any safety concerns:				
Ability to Perform Job:				
Return to Work Status: # Regular Duties # Alternate Duties Return to Work Date:				

Work Restrictions:		
Employee is ***NOT*** capable of:	**Check**	**Comments; if necessary, expand on restrictions**
Sitting		
Walking: Flat Ground		
Uneven Ground		
Repetitive use of injured area		
Lifting/carrying/pushing/pulling: Light		
Moderate		
Heavy		
Climbing ladders		
Climbing stairs		
Working at heights (indicate height)		
Exposure of Injury to: Heat		
Cold		
Dust		
Wet		
Other Restrictions		
Operation of Mobile Equipment		

Duration of Restriction(s): Shifts: #1 # 2 # 3 #4 # 5+	Weeks: #1 # 2 # 3 #4 # 5+
Physician's Name/Address/Phone:	
Signature of Physician:	Date: