Nisga'a Lisims Government

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PROTECTED: (When completed) For Authorized Personnel ONLY

# Medical Report

For Persons with Disability Level I (DBL I)

| **A. Personal Information** | | |
|---|---|---|
| Last Name | First Name | Middle Name |
| Date of Birth (YYYY-MMM-DD) | Personal Health Number | Social Insurance Number |

| **B. Authority to release information (Completed by client)** | | |
|---|---|---|
| I authorize the medical practitioner indicated below to complete this assessment and to disclose medical information concerning myself to the Administering Authority and to Nisga'a Lisims Government | | |
| Signature of Client | Date signed (YYYY-MMM-DD) | Signature of Witness |

**C. Medical assessment (Completed by Medical Practitioner) Please print**

1. Medical Condition: Date of onset
   a. Primary Medical Condition: _____ _____
   b. Secondary Medical Condition: _____ _____
   c. Severity of Medical Condition: ☐ Mild ☐ Moderate ☐ Severe
   d. Has the medical condition existed for at least 1 year: ☐ Yes ☐ No

2. Prognosis:
   a. Expected duration of Medical Condition: ☐ At least 6 months ☐ More than 18 months
   ☐ Additional comments:

_____

   b. Medical Condition is episodic in nature ☐ Yes ☐ No
      i. How frequently have the episodes occurred? _____
      ii. How frequently are they likely to occur? _____

c. Please describe the nature and reasons for any restrictions in employment, specific to the above Medical Conditions:

d. Please describe any steps that can be taken to overcome/reduce restrictions to employment (i.e. light duty)

e. Please describe any workplace supports recommended to assist in employment (i.e. flexible work hours)

| 3. Certification of Examining Medical Practitioner<br>I, _____<br>Am a licensed medical practitioner specializing in<br>_____.<br>I have examined the patient and this report contains my findings and considered opinion at this time. I have been the patient's medical practitioner for:<br>☐ 6 months or less ☐ Over 6 months<br>If under 6 months:<br>☐ I have examined previous medical records<br>☐ I have not examined previous medical records | Address, including postal code (stamp or print)<br><br>Telephone number: _____ |
|---|---|
| Signature of Medical Practitioner | Date (YYYY-MMM-DD) |

*NSD-16*