**MEDICAL CERTIFICATE TEMPLATE**

**This certificate is to establish that the patient named below is in good physical and mental condition as to not adversely affect the health or safety of those they care for as a care provider.**

**PATIENT INFORMATION and AUTHORIZATION** (To be completed by the PATIENT)

|  |  |
| --- | --- |
| **Name:** | **Date of Birth:** |
| I authorize the release of this medical information to my potential employer and the Bermuda Health Council appointed inspectors to ensure compliance with the Residential Care Home and Nursing Home Act 1999, Regulations 2001 and Code of Practice and/or Bermuda Health Council home care provider registration requirements. |
| **Signature:** |  **Date:** |

**MEDICAL INFORMATION** (To be completed by PHYSICAN)

|  |  |
| --- | --- |
| 1. **Check to indicate general health status of patient:**

*If any are unchecked provide an explanation in comments section*  | [ ]  Free from active infections of communicable diseases[ ] Free from substance abuse[ ]  Mentally fit and capable of caring for vulnerable persons |
| 1. **Check to indicate if your patient has the physical capacity to perform the functions of their post:**

*Specify their physical ability (e.g. able to perform assisted lifting and handling etc) and disclose previous relevant injuries regardless if able to perform functions. e.g. 2014 back injury but no* current concerns for lifting and handling | [ ]  **Yes** Specify:[ ]  **No** Specify: |
| 1. **Check to indicate patient’s current immunization status**:

*This is to help identify who may be at risk based on immunization status.*  | [ ]  Influenza vaccine Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Measles, Mumps, Rubella Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Varicella (chickenpox): Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Polio: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Hepatitis B: Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Tetanus, Diphtheria, Pertussis Date:\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Other (see Adult Immunization Schedule)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Comments:** |
| **Date:** | **Physician Signature:** |
| **Contact Number:** | **Print Name:** |