GOVERNMENT OF BERMUDA

Ministry of Health

CONFIDENTIAL

MEDICAL CERTIFICATE FOR CARE HOME and HOME CARE PROVIDERS

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 Ministry of Health inspectors to ensure compliance with the Residential Care home and Nursing Home Act 1999, Regulations 2001 and Code of Practice or ADS home care provider registration requirements. **Signature:**	 **Date:**

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

This individual is or will be employed in a care home or home care setting. This form is to establish that the person named above is in good physical and mental condition as to not adversely affect the health or safety of those they care for.

Check to indicate if the patient is:

- ☐ Free from communicable disease
- ☐ Free from substance abuse
- ☐ Mentally fit and capable of caring for persons requiring care services or managing care homes

Provide details on the next page if any box above is unchecked or there is information to be considered in relation to your assessment.

Does the person have the physical capacity to perform the functions of their post?

- ☐ Yes ,specify e.g. assist with lifting and handling etc
- ☐ No-specify:

Immunization status:

- ☐ Influenza vaccine Date:_______________
- ☐ Adult Immunization Schedule: indicate which ones were received and when:

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Comments (Please use back of this form if additional space is needed)	
Physician's Signature:	**Date:**
Print Name:	**Telephone Number:**

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