GOVERNMENT OF BERMUDA
Ministry of Health

# MEDICAL CERTIFICATE FOR CARE PROVIDERS

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 persons they care for.

**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 appointed inspectors to ensure compliance with:

☐ the Residential Care Home and Nursing Home Act 1999, Regulations 2001 and Code of Practice and/or Ageing and Disability Services home care provider registration requirements or,

☐ the Day Care Centre Regulations 1999 and/or Child Care Regulation Programme's registration requirements.

**Signature:** **Date:**

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

| | |
|---|---|
| **1. Check to indicate general health status of patient:**<br>*If any are unchecked provide an explanation in comments section* | ☐ Free from active infections of communicable diseases<br>☐ Free from substance abuse<br>☐ Mentally fit and capable of caring for vulnerable persons |
| **2. Check to indicate if your patient has the physical capacity to perform the functions of their post:**<br>*Must have physical ability (i.e. mobile and able to lift, squat, assist their care recipients, in and out of a building, car, up/down steps etc).* | ☐ **Yes**<br>☐ **No** Specify:<br>☐ Drive a car, if necessary. |
| **3. Check to indicate patient's current vaccine status (As known. No testing required)**:<br>*This to prompt discussion of identifying who may be at risk and advise if vaccines are recommended due to care giver or care recipient(s) risk factors. Additionally it documents history in event of outbreak.* | ☐ Influenza vaccine Date:_____<br>☐ Measles, Mumps, Rubella Date:_____<br>☐ Varicella (chickenpox): Date:_____<br>☐ Polio: Date_____<br>☐ Hepatitis B: Date_____<br>☐ Tetanus, Diphtheria, Pertussis Date:_____<br>☐ Other (see Adult Immunization Schedule)_____ |

**Comments:**

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|---|---|
| **Date:** | **Physician Signature:** |
| **Contact Number:** | **Print Name:** |