**Medical Certificate To Support An Application for Medical Exemption from Participation**

*MERZ Housing Co-operative Inc. provides long term affordable housing for people on low incomes. We have approximately* ***30*** *members who have signed a Participation Agreement which means they have agreed to share in the work of managing the Co-operative and its* ***30*** *properties. Our rules require that every Member should participate to the best of their ability but we do allow for modified participation when a Member is injured, becomes ill or has reduced capacity.*

*This document is used by Members when applying for an* ***exemption from participation*** *on medical grounds. For an exemption to be granted we require information from a medical practitioner to help us make a fair and transparent decision about whether an exemption should be granted or other action should be taken.*

I give permission for the proper use of my personal information by MERZ Housing Co-operative Inc. in order to assess this application.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Member’s signature Date

***To be completed by Medical Practitioner:***

***The member is required to provide you with a copy of the Modified Job Description to assist your assessment of their medical condition and its implications for their ability to participate.***

Member’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Consultation Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Modified Job Description provided 🞎 Yes 🞎 No

Period during which the Member is likely to be affected (*note – our policies allow an exemption for a maximum of six months at a time):*

from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate how your assessment of the Member’s condition was made:

[ ] Information provided by the Member [ ] Examination of the Member on / /

Provider’s Stamp

Practitioner’s name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_