



LANGLEY ASSOCIATION  
FOR COMMUNITY LIVING  
1959 - 2009

## DOCTOR'S CERTIFICATE OF GOOD HEALTH

Name: \_\_\_\_\_

Address: \_\_\_\_\_

I have known this patient for the past \_\_\_\_\_ (years/months)

1. This patient is presently in good physical and mental health and to my knowledge, has no chronic or long-term health problems.
2. This patient is, to the best of my knowledge, able to perform all the necessary duties of a Community Support Worker to provide support to vulnerable adults with developmental disabilities and when necessary, lifts and transfer of physically disabled individuals.
3. This patient is in compliance with the immunization program of the Ministry of Health.

Date: \_\_\_\_\_ Physician: \_\_\_\_\_  
(Signature)

Name of Physician: \_\_\_\_\_  
(Please Print)

Address of Physician: \_\_\_\_\_

Phone #: \_\_\_\_\_

U:\FORMS - HIRING\DOCTOR'S CERTIFICATE  
REVISED: AUGUST 2006  
RE: POLICY 4.1



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