Attending Physician's Statement

Instructions: Employees complete Section A and the Physician completes Section B and D and possibly C, depending on the circumstance.

Employees are responsible for ensuring the form is completed by their Physician and forwarded to the Occupational Health Unit.

PART A – Employee Information & Consent

To be completed by employee

Employee's Name: _____ Unit/Department: _____

Manager's Name: _____ JobTitle: _____

Home Phone #: _____ First Day Absence: _____

By completing and signing this form, I hereby authorize my health care practitioner to release limitations/restrictions and/or functional information pertaining to my current absence to Mackenzie Health's Occupational Health Unit. This information is for the purpose of determining my fitness to work and/or the need for any required accommodation and/or to substantiate my absence due to illness and/or eligibility for benefits.

In addition, I authorize Mackenzie Health's Occupational Health Unit/Physician to contact my health care practitioner for the development and implementation of my Early and Safe Return to Work Plan, if required.

This authorization is effective (a) as a single authorization or (b) for the duration of my current disability **(circle choice).** I understand that I may revoke this authorization at any time either in a written document signed by me, or electronically, provided that such electronic revocation is sufficient authentication to establish my identity.

Employee's Signature: _____ Date:_____

All medical information received will be kept in strict confidence in the employee's health file.

Part B - Illness/Injury Information

(To be completed by Treating Physician)

Mackenzie Health is committed to offering modified or graduated "RTW" programs designed to ensure a safe and early return to work of employees who are recovering from injury or illness.

Type of Disability:

☐ Non-occupational injury/illness ☐ Occupational injury/illness (WSIB) ☐ Optional Medical Procedure (not covered by OHIP) ☐ MVA

General nature of Illness/injury (a general statement of a person's illness or injury): _____

_____

_____

Is the current illness a communicable disease? □ **Yes** □ **No**

If yes, has the communicable disease been reported to Public Health as required by law? □ Yes □ No

Date of first appointment: _____ **Date of most recent appointment:** _____

Date of next scheduled appointment: _____

Is the employee being referred to a Treating Specialist? □ **Yes** □ **No**

Is, or was the employee hospitalized for this injury/illness? □ **Yes** □ **No** **From:** _____ **To:** _____

In my opinion, supported by objective medical evidence, the employee is/has been:

□ **Totally Disabled** □ **Not Totally Disabled** from performing his/her regular duties

Date total disability commenced: _____

Anticipated date of return to work: _____

Prognosis for return to regular duties: □ **Good** □ **Poor** □ **Uncertain**

I confirm the employee is under my active and continuous care and is following the treatment I have prescribed:

□ **Yes** □ **No**

Please describe the treatment plan in general terms:

If employee is <u>not</u> returning to work, or does <u>not</u> require any modified duties or accommodation, please proceed to Part D . DO NOT COMPLETE PART C.

Part C - Abilities, Restrictions and Limitations: to be completed only if the employee is returning to work with restrictions. *(To be completed by Treating Physician)*

Physical Capabilities:

□ **Sedentary Duties:** • Sitting • No requirement to lift, carry, push/pull or climb
□ **Light Duties:** • Standing and/or sitting • Walking from one task area to another • No climbing • Limited carrying - no greater than 5 kgs. • Limited lifting, pushing or pulling - no greater than 10 kgs.
□ **Medium Duties:** • Standing, walking, sitting as required • Limited lifting, carrying, pushing or pulling no greater than 15 kg • Limited climbing

Cognitive Capabilities: if applicable, please indicate limitations in cognitive function:

Coherent	□ Yes □ No
Judgment	□ Good □ Adequate □ Poor
Concentration	□ Good □ Adequate □ Poor
This individual can work	□ Independently □ With supervision □ With Assistance

Other restrictions (please indicate):

Recommended RTW: □ **regular hours** □ **graduated (details):** _____

_____

Estimated duration of restrictions/graduated plan: _____

Part D: Physician Information

Physician's Name:	
Address:	
Signature:	Date:
Phone:	Office Stamp:
Fax:	

Thank you for your assistance. This form can be faxed back to the confidential fax of OHS at 905-883-2149 or emailed to OccupationalHealthUnit@MackenzieHealth.ca if you have a secure One Mail email account.