St. Joseph's Healthcare Hamilton

ATTENDING PHYSICIAN STATEMENT

FORM B

- *For all employees*
- *For ONA employees with date of employment after Jan1, 2006 (1992 HOODIP)*

A. EMPLOYEE INFORMATION

- *It is your responsibility to provide an Attending Physician Statement every 2 weeks to support your continued medical absence unless otherwise arranged with the Health Office Case Manager.*

Name: _____ **Job Title:** _____

Last Day Worked: _____ **DOB:** _____

Consent: Must be complete by the Employee

I consent to allow Occupational Health & Safety Services to provide information related to my fitness for work, including capabilities, functional limitations and any accommodation needs to my Manager/ Supervisor and Union Representation (if applicable)

Employee Signature: _____ **Contact Phone #**_____

Personal E-mail: _____

Reimbursement

- Pay treating practitioner directly.
- Submit receipts to the Occupational Health Office **within 3 months** – must include your physician's contact information (name, address, phone number)

B. PHYSICIANS INSTRUCTIONS:

- All information and sections requested below must be fully completed to ensure the employer can determine the employee's eligibility for salary replacement benefits or approval of unpaid medical leave of absence
- St. Joseph's Healthcare Hamilton supports early and safe return to work

Date first incapable of working: _____

Date first assessed to be total disabled from all duties of _____ position. Date:_____

Dates examined related to this illness: _____

Specified period of expected absence (total disability): _____

Nature of Illness (No diagnosis or medical history): _____

Employee is under your active and continuous care: Yes ☐ No ☐ _____

Employee is actively in treatment: Yes ☐ No ☐ _____

Employee is compliant with treatment: Yes ☐ No ☐ _____

Anticipated date of complete recovery: _____

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Employee Name:_____

DOB:_____

Please complete Section 1 and 2 below (To be completed by treatment provider)

1. Please specify functional limitations only. The employer will determine tasks for accommodation.

Walking Standing Sitting: _____

Lifting Floor to Waist: ☐ Less than 10kg ☐ Less than 25kg ☐ Other _____

Lifting Waist to Shoulder: ☐ Less than 10kg ☐ Less than 25kg ☐ Other _____

Above Shoulder activity: _____

Limited Ability to use hand: ☐ hold objects ☐ grip ☐ write ☐ type

Repetitive Movement of: _____ Pushing/Pulling: _____

Chemical/ Environmental Exposure to: _____

Attend to detail: _____ Perform multiple tasks: _____

Exercise appropriate judgement and behaviour: _____

Other:

From the date of this assessment, the above will apply for approximately: _____

Have you discussed return to work with your patient? _____

2. Recommendation for Work:

☐ **Fit to return to work full duties** **Date:** _____

☐ **Fit for modified work** **Expected duration:** _____ ☐ **Regular Hour** ☐ **Graduated hours**

Comments:

☐ **Unfit to work** **Expected duration:** _____

Reassessment Date: _____

I certify that I am a qualified medical health professional and that I have personally assessed and treated the above patient/employee.

Physician's Name (please print): _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____

Completed form to be returned by email or fax:
Occupational Health and Safety Services
St. Joseph's Healthcare Hamilton
E: Hoffice@stjoes.ca **F: 905-521-6111**