



ATTENDING PHYSICIAN'S STATEMENT

FORM A

- For ONA employees with date of employment prior to Jan 1, 2006 (1980 HOODIP)

RETURN BY DATE: _____

Employee Information:

Name: _____ Job Title: _____

LAST DAY WORKED: _____ DOB: _____

Employee Instructions for Reimbursement:

- Payment for completion of form must be made directly to your Treating Practitioner.
- Receipts must be submitted to Employee Health Office **within 3 (three) months** of transaction date for reimbursement.

Consent: To be completed by the employee

I consent to allow Occupational Health & Safety Services (OH & S) to provide information related to my fitness for work and any accommodation needs to my Manager/Supervisor and Union Representative (if applicable).

Employee Signature: _____ Contact Ph.# _____

Information to be completed by Physician:

All information and sections requested 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.

Date first incapable of working: _____

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

Dates examined related to this illness: _____

Specified period of expected absence (total disability): _____

Nature of illness or injury (no diagnosis or medical history): _____

Is employee receiving treatment: Yes No

Anticipated date of complete recovery: _____

Continued on Page 2

Information to be completed by Physician continued:

St. Joseph's Healthcare Hamilton supports early and safe return to work. We are committed to providing modified duties/work accommodation to support the recovery process. Please complete the appropriate box below.

<input type="checkbox"/> Fit to return to full duties:	Date: _____
<input type="checkbox"/> Fit for modified work: Please specify functional limitations:	
Date: _____	Expected duration: _____ Regular Hours <input type="checkbox"/> Graduated Hours <input type="checkbox"/>
Walking Standing Sitting	<input type="checkbox"/> _____
Lifting Floor to Waist:	<input type="checkbox"/> less than 10 kg <input type="checkbox"/> less than 25 kg <input type="checkbox"/> other
Lifting Waist to Shoulder:	<input type="checkbox"/> less than 10 kg <input type="checkbox"/> less than 25 kg <input type="checkbox"/> other
Above shoulder activity:	_____
Limited ability to use hand:	<input type="checkbox"/> hold objects <input type="checkbox"/> grip <input type="checkbox"/> write <input type="checkbox"/> type
Repetitive Movement of: _____	Pushing/ Pulling: _____
Chemical/ Environmental Exposure to: _____	
Attend to detail: _____	Perform multiple tasks: _____
Exercise appropriate judgement and behaviour: _____	
Other: _____	

Reassessment Date: _____	
<input type="checkbox"/> Unfit to work: Please describe the functional impairment that is preventing this employee from working:	

Duration: _____	Reassessment Date: _____

By affixing my signature below, 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 mail or fax by due date outlined on page 1.

Attention: _____

Occupational Health & Safety Services – Charlton Campus
St. Joseph's Healthcare Hamilton
50 Charlton Avenue East
Hamilton, Ontario L8N 4A6
Ph: 905-522-1155 x33344 Fax: 905-521-6111

Occupational Health & Safety Services – West 5th Campus
St. Joseph's Healthcare Hamilton
100 West 5th Box 585
Hamilton, Ontario L8N 3K7
Ph: 905-522-1155 x36361 Fax: 905-381-5621

Employee Name:
DOB: