St. Joseph's Healthcare Hamilton

ATTENDING PHYSICIAN'S STATEMENT

FORM B

- *For all employees*
- *For ONA employees with date of employment after Jan 1, 2006 (1992 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): _____

Employee is under your active and continuous care: YES ☐ NO ☐ _____

Please provide a general description of the treatment plan: _____

_____

Employee is compliant with 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.

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

☐ **Fit for modified work: Please specify functional limitations:**

Date: _____ Expected duration: _____ Regular Hours ☐ Graduated Hours ☐

Walking Standing Sitting ☐ _____

Lifting Floor to Waist: ☐ less than 10 kg ☐ less than 25 kg ☐ other

Lifting Waist to Shoulder: ☐ less than 10 kg ☐ less than 25 kg ☐ 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: _____

_____

_____

Reassessment Date: _____

☐ **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: