ATTENDING PHYSICIAN STATEMENT

FORM A

- *For ONA employees with date of employment prior to Jan 1, 2006 (1980 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 Occupational Health Nurse or Disability Management Coordinator.*

Name: _____ **Job Title**: _____

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

Consent: Must be completed 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 Representative (if applicable).

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

Reimbursement

- Pay Treating Practitioner directly.
- Submit receipt to Disability Management Institute **within 3 months** – must include your physician's contact information (name, address, phone number).

B. PHYSICIAN'S 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 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

Employee Name: _____
DOB: _____

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: _____

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 to:

Occupational Health and Safety Services
St. Joseph's Healthcare Hamilton
C/O Disability Management Insitute (DMI)
E: employer.services@mydmi.ca
F: 1-855-734-6402

Disability Management Institute Authorization

for Collection, Use, and Disclosure of Personal Information

Collecting, using, and disclosing your personal information

We collect, use, and disclose your personal information so we can:

- establish and maintain communications with you;
- review, assess and / or investigate your claims;
- detect and prevent fraud;
- provide our programs, manage your disability leave and insurance benefits;
- make recommendations on rehabilitation and return to work to help your employer accommodate you in the workplace;
- manage related claims for your employer;
- evaluate and improve our services;
- compile insurance statistics; and
- comply with the law.

Virtual and Telecommunications

Some of DMI's programs are delivered via Tele-assessment which includes assessment services via telephone or secure video conferencing. The virtual platform is fully secure and compliant with Canadian Data Protection regulations, including the Personal Information Protection and Electronic Documents Act (PIPEDA) and the Personal Information Protection Act (PHIPA).

In addition to standard limitations of confidentiality, teleassessment services have unique considerations and limitations in terms of confidentiality. Please consider the following:

- All images from the teleassessment are considered confidential and will not be stored or used in any way. No recordings of sessions will be made unless there is expressed reason and consent to do so.
- There may be instances where an assessment session is interrupted due to screen distortions, poor internet signal quality, or unforeseen technical problems. Should this occur your session will be rescheduled.
- Confidentiality will be ensured on the assessor's end via a private room for the session. The client assumes responsibility for ensuring the privacy of the space that they conduct the assessment in. It is recommended that clients choose an environment for receiving services that is comfortable, free from distraction and potential disruption.

Exchanging your personal information

We and our authorized representatives may collect and exchange personal information about you as permitted by law with these persons, organizations,or groups when relevant and necessary:

- your employer if the information is relevant for the purpose of managing your absence, assessing your claim, and for return-to-work planning, except details relating to diagnosis, treatments, or medications;
- your treating healthcare providers, including any licensed medical practitioner or health professional, clinic, or medically related facility;
- our medical and rehabilitation agents and consultants, and independent medical examiners and functional capacity assessors
- your employer's insurance company, for the purpose of submitting your claim for Long-Term Disability benefits;
- other insurers, or benefit providers with your specific advance consent and authorization;

Our organization

The consent you provide by signing below applies to our organization, which consists of a number of companies. DMI (Disability Management Institute Inc.) is a member of the GroupHEALTH Family of Companies. These companies provide shared services to each other. It also includes future and potentially related entities, such as entities that join, or consider joining, our organization or that may acquire all or part of our business.

Questions and concerns

We welcome questions about our privacy practices. Please contact our Privacy Officer by telephone at 1-866-963-9995 or by email at privacy@mydmi.ca. For a copy of our Privacy Policy see www.disabilityinstitute.com/privacy-policy/

By signing below you confirm that:

- you have read, understand, and agree with the contents of this form and authorize us to collect, use, and disclose your personal information as described herein;
- this consent shall be valid for the length of time necessary for us to achieve the purposes listed above;
- you may withdraw this consent at any time by giving us a written notice of withdrawal;
- you understand that withdrawal of your consent might result in us being unable to provide you with our services;
- a photocopy or electronic copy of this authorization shall be considered as effective and valid as the original.

_____	_____	_____
Date	Print Name	Signature or Print Name (if Electronic)