

SICK LEAVE BENEFITS

We are sorry to hear that you are ill/disabled and unable to report to work at this time.

The purpose of this letter is to advise you of the benefits and responsibilities under the sick leave program.

Benefits commence on the first day of lost time due to a non-occupational accident, illness, or hospitalization. You will initially be paid your wages by direct banking as determined by your length of service. This benefit could continue for a maximum of 15 calendar weeks.

Please have your treating physician complete the Attending Physician's Statement as soon as possible to ensure your claim is processed accurately. A delay in submitting documentation could subsequently delay payment of this benefit.

Headwaters Health Care Centre has an active Early and Safe Return-To-Work Program which assists and encourages workers with injury and illness to return to safe and valued work as soon as physically appropriate.

Our effort to accommodate is meant to provide less physically demanding work and full wages while progressing toward pre-disability job duties. We also believe that it is important for our staff to maintain contact with their employers, co-workers and the work environment throughout the recovery process.

It is important that you update both your Manager and the Employee Health Services of your progress and return to work date.

If you have any questions, please do not hesitate to call the Employee Health Services at (519) 941-2702 x 2801.

Thank you for your co-operation, and we look forward to your return.

Employee Health Services

Attending Physician's Statement

Mail or fax to Confidential Fax # 519 941-2342

Occupational Health

1. Please Print
2. Part 1 to be completed and signed by the patient
3. Part 2 to be completed by physician

Part 1: Patient Authorization		Dept:
Name:		
<p>I authorize any person or organization, including but not limited to, any licensed practitioner, healthcare professional, hospital, clinic, or other related medical facility, to release any information requested with respect to this claim to Employee Health Services at Headwaters Health Care Centre. I also agree that if medical examinations are necessary to assess my disability, that I will fully cooperate for such examinations, and that any health care professional or organization conducting such examinations may release information regarding my fitness to return to work, functional abilities and expected date of return to work. I certify that the information furnished by me in support of this claim is accurate and complete.</p>		
Patient's Signature:		Date:
Part 2: Attending Physician's Statement		
<p>1. Nature of present condition:</p> <p style="margin-left: 20px;">a) Primary:</p> <p style="margin-left: 20px;">b) Additional conditions or complications which might affect duration of absence from work:</p>		
<p>2. To the best of your knowledge</p> <p>a) Indicate when symptoms first appeared or accident happened (dd/mm/yy)</p>	<p>b) Has the patient had a similar condition? If yes, please provide details</p>	
<p>3. Is the condition due to injury or illness arising out of patient's employment? Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>4. Is this condition cosmetic or due to a cosmetic procedure complication? Yes <input type="checkbox"/> No <input type="checkbox"/></p>		
<p>5. If the patient is pregnant indicate expected date of confinement (dd/mm/yy)</p>		
<p>6. Date of last physician's appointment: (dd/mm/yy)</p>	<p>Last day employee worked: (dd/mm/yy)</p>	
<p>7. a) Date of hospital in-patient admission</p> <p style="margin-left: 20px;">b) Date of emergency treatment</p>	<p>8. Date of discharge (if applicable)</p>	
<p>9. To the best of your knowledge, is the patient unable to work at own occupation? If yes, please indicate a return to work date:</p>	<p>9b. Is or will the patient a suitable candidate for a modified work program? If yes, give date patient could return to work and complete the attached Functional Abilities Form:</p>	
<p>10. Remarks – Please provide any comments /further details which would be helpful.</p>		
<p>11. The information provided was based solely on patient history <input type="checkbox"/> based on history and physical examination <input type="checkbox"/></p>		
<p>Name of attending physician or primary treating practitioner (please print):</p>	<p>Specialty:</p>	<p>Telephone Number:</p>
<p>Address:</p>		
<p>Signature:</p>		<p>Date:</p>

SICK LEAVE CLAIM FORM

To be completed by the employee (Please print clearly)

Employee name: _____ Department: _____

Occupation: _____

Present Address: _____

Phone #: () _____

Date of Birth: (mm/dd/yy) _____ Date of Hire: (mm/dd/yy) _____

Date you were first disabled by this illness or injury: _____

If you were hospitalized as a bed patient:

Name of Hospital: _____

Date admitted: (mm/dd/yy) _____ Date Discharged: (mm/dd/yy) _____

If an accident occurred:

Name of treating Hospital: _____

Date of Accident: (mm/dd/yy) _____ Date of Treatment: (mm/dd/yy) _____

Details of Accident: _____

At work? (circle) Yes No Elsewhere? _____

Motor Vehicle Accident? (circle) Yes No

Is the absence related to a cosmetic procedure or complications of a cosmetic procedure? Yes No

RESPONSIBILITIES OF EMPLOYEE

1. This form must be completed and returned to the Employee Health Services as soon as possible to ensure accurate tracking of your claim.
2. Please have your doctor complete the entire Attending Physician's Statement and Functional Abilities Form (as necessary).
3. Inform your Manager and Employee Health Services regarding your absence:
 - i) on a regular basis about your progress
 - ii) your return to work date
 - iii) need to extend time off
 - iv) preparedness to participate in a Return to Work Program