HEADWATERS
Health Care Centre

ONGOING

APPLICATION FOR MEDICAL ABSENCE

Application Form for Short Term Disability Benefits for more than10 days Absence

PLEASE NOTE: All sections must be completed in order for this application to be processed

EMPLOYEE INFORMATION: to be completed by employee **(Please print)**

Name:			*Department:*		
Phone(H):	*Phone(W):*				
Job Title:	*First Day Absent:*				
Manager:			*No. of hours per shift:*		
	Full Time		*Part Time*		*Casual*

I hereby authorize Dr. ___________________________ to disclose to Occupational Health (OH) the information requested below regarding my current injury, illness and/or treatment plan and to provide further clarification regarding my fitness to perform duties of my job (the Information).

I understand that the Information will be disclosed to OH for the purposes of supporting my absence and/or supporting my needs for accommodation, and for purposes related to or incidental there to. I understand that the Information will be kept in my confidential OH file and that no part of the information will be disclosed to a third party without my consent, except where otherwise required or permitted by law.

I understand that, for the purposes of facilitating my return to work, information related to my ability to return to work and my accommodation requirements will be shared with my manager/supervisor and with the Human Resources department of HHCC. This consent will remain in effect until I return to full duties and hours of my position, until I revoke it in writing.

_________________________________ ___________________________________

Employee Signature *Date*

ILLNESS/INJURY INFORMATION: **to be completed by treating physician**

Please circle the applicable category: *Musculoskeletal, Circulatory, Psychological, Pregnancy, Infectious, Cancer, Accident, Neurological, Miscellaneous*	*Date of Onset:*
Signs/Symptoms:	
Date first assessed:	*Date last assessed:*
Did this injury/illness arise out of employment at HHCC? □ *No* □ *Yes*	
Is this a recurring condition? □ No □ Yes	Has referral been made to a specialist? □ No □ Yes Please specify specialities:
Treatment Plan/dates:	
Please attach any supporting documentation (e.g. X-ray reports, consult notes) as you see fit.	

PLEASE COMPLETE REVERSE SIDE

Please return to the Occupational Health and Safety Department
***CONFIDENTIAL FAX*: (519) 941-2342. REMEMBER TO FAX BOTH SIDES.**

Patient Name: ____

Temporary Modified Work Information: to be completed by treating practitioner

We support the CMA and OMA in recognizing the importance of a person returning to all possible functional activities relevant to his/her life as soon as possible after an injury or illness, and that a prolonged absence from one's normal roles, including from the workplace, is detrimental to a person's mental, physical and social well-being.

It is my professional opinion that this individual is currently (**please pick one**)

☐ **Fit to return to FULL duties OR**

☐ **Fit to return to MODIFIED duties (**employees on modified duties will be medically monitored**)**

Headwaters Health Care Centre will employ a similar methodology as the Workplace Safety and Insurance Board to define an employee's abilities. Functional Abilities are a snap shot in time and may require further communication to assist both the employee and the Hospital in achieving a suitable and/or comparable Early and Safe Return to Work.

Length of Restrictions: (1) Temporary _________ if so duration ___________weeks (2) Permanent _______

WALKING	□ unable □ < 15 min □ 15-30 min □ 30-60 min
STANDING	□ < 15 min □ < 15-30 min □ 30-60 min □ >60 min
SITTING	□ < 15 min □ < 15-30 min □ 30-60 min □ >60 min
LIFTING (floor-waist)	□ unable □ <7kg/15 lb □ <14kg/30 lb □ <25kg/55lb □ minimal (<10%) □ occasional (11-34%) □ frequent (35-66%)
LIFTING (overhead)	□ unable □ <2.3kg/5 lb □ <7kg/15 lb □ <14kg/30lb □ minimal (<10%) □ occasional (11-34%) □ frequent (35-66%)
CLIMBING STAIRS/LADDER	□ minimal (<10%) □ occasional (11-34%) □ frequent (35-66%)
GRIPPING	□ minimal (<10%) □ occasional (11-34%) □ frequent (35-66%)
REACHING ABOVE/BELOW SHOULDER (please specify)	□ minimal (<10%) □ occasional (11-34%) □ frequent (35-66%)
BENDING/TWISTING (cervical/lumbar spine) (please specify)	□ minimal (<10%) □ occasional (11-34%) □ frequent (35-66%)
SHIFT/HOUR RESTRICTION (please specify and explain)	
COGNITIVE	**coherent** □ yes □ no **judgement** □ good □ adequate □ poor **concentration** □ good □ adequate □ poor **can this person work** □ independently? □ with supervision? □ with assistance?

☐ **Unfit to work** (i.e. TOTALLY DISABLED the employee is hospitalized or otherwise incapable of performing acts of daily living)

Please state reasons why the employee cannot return to modified duties, as per the Canadian Medical Association's GUIDELINES FOR RETURN TO WORK AFTER ILLNESS OR INJURY and as per the legislative requirements for accommodation.

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Reassessment Date: ____________________________**Expected duration of TOTAL disability** ____________________________

MD Signature:		***Date:***	***Office Stamp***
MD Name:			
Address:			
City:		***Postal Code:***	
Telephone:	***Fax:***		

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