



**ATTENDING PHYSICIAN STATEMENT / FUNCTIONAL ABILITIES FORM**  
**ONGOING**  
**APPLICATION FOR MEDICAL ABSENCE**

Application Form for Short Term Disability Benefits for more than 3 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
<p>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).</p> <p>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.</p> <p>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.</p>					
_____ Employee Signature				_____ Date	

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

<b>Please circle the applicable category:</b> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Is this a recurring condition? <input type="checkbox"/> No <input type="checkbox"/> Yes	Has referral been made to a specialist? <input type="checkbox"/> No <input type="checkbox"/> 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**

**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)**

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

**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	<input type="checkbox"/> unable	<input type="checkbox"/> < 15 min	<input type="checkbox"/> 15-30 min	<input type="checkbox"/> 30-60 min
STANDING	<input type="checkbox"/> < 15 min	<input type="checkbox"/> < 15-30 min	<input type="checkbox"/> 30-60 min	<input type="checkbox"/> >60 min
SITTING	<input type="checkbox"/> < 15 min	<input type="checkbox"/> < 15-30 min	<input type="checkbox"/> 30-60 min	<input type="checkbox"/> >60 min
LIFTING (floor-waist)	<input type="checkbox"/> unable <input type="checkbox"/> minimal (<10%)	<input type="checkbox"/> <7kg/15 lb <input type="checkbox"/> occasional (11-34%)	<input type="checkbox"/> <14kg/30 lb <input type="checkbox"/> frequent (35-66%)	<input type="checkbox"/> <25kg/55lb
LIFTING (waist to shoulder)	unable <input type="checkbox"/> minimal (<10%)	<input type="checkbox"/> <7kg/15 lb <input type="checkbox"/> occasional (11-34%)	<input type="checkbox"/> <14kg/30 lb <input type="checkbox"/> frequent (35-66%)	<input type="checkbox"/> <25kg/55lb
LIFTING (overhead)	<input type="checkbox"/> unable <input type="checkbox"/> minimal (<10%)	<input type="checkbox"/> <2.3kg/5 lb <input type="checkbox"/> occasional (11-34%)	<input type="checkbox"/> <7kg/15 lb <input type="checkbox"/> frequent (35-66%)	<input type="checkbox"/> <14kg/30lb
CLIMBING STAIRS/LADDER	<input type="checkbox"/> minimal (<10%)	<input type="checkbox"/> occasional (11-34%)	<input type="checkbox"/> frequent (35-66%)	
PUSHING/PULLING	<input type="checkbox"/> (5-10 lbs force)	<input type="checkbox"/> (10-20 lbs force)	<input type="checkbox"/> (20-30 lbs force)	<input type="checkbox"/> (>30 lbs force)
GRIPPING/PINCHING	<input type="checkbox"/> minimal (<10%)	<input type="checkbox"/> occasional (11-34%)	<input type="checkbox"/> frequent (35-66%)	
REACHING ABOVE/BELOW SHOULDER (please specify)	<input type="checkbox"/> minimal (<10%)	<input type="checkbox"/> occasional (11-34%)	<input type="checkbox"/> frequent (35-66%)	
BENDING/TWISTING (cervical/lumbar spine) (please specify)	<input type="checkbox"/> minimal (<10%)	<input type="checkbox"/> occasional (11-34%)	<input type="checkbox"/> frequent (35-66%)	
SHIFT/HOUR RESTRICTION (please specify and explain)				
COGNITIVE	<b>coherent</b> <input type="checkbox"/> yes <input type="checkbox"/> no <b>judgement</b> <input type="checkbox"/> good <input type="checkbox"/> adequate <input type="checkbox"/> poor <b>concentration</b> <input type="checkbox"/> good <input type="checkbox"/> adequate <input type="checkbox"/> poor <b>can this person work</b> <input type="checkbox"/> independently? <input type="checkbox"/> with supervision? <input type="checkbox"/> with assistance?			

**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.**

\_\_\_\_\_

**Reassessment Date:** \_\_\_\_\_ **Expected duration of TOTAL disability** \_\_\_\_\_

<b>MD Signature:</b>		<b>Date:</b>	<b>Office Stamp</b>
<b>MD Name:</b>			
<b>Address:</b>			
<b>City:</b>	<b>Postal Code:</b>		
<b>Telephone:</b>	<b>Fax:</b>		