NORTH YORK GENERAL

Occupational Health Safety and Wellness
4001 Leslie Street
Toronto, ON M2K 1E1
Tel: 416 756-6070
Fax: 416 756-6195

Attending Physician's Statement

The Ontario Medical Association (OMA) outlines in its **"Position in Support of Timely Return To Work (RTW) Programs and the role of Physicians**" that physicians should provide objective reports on impairment, medical restrictions and other supporting advice to the employee. In exchange for this information, the employers will offer the particular employee a plan for returning to suitable work in a timely fashion.

EMPLOYEE INFORMATION:

NAME:	**DEPT:**	
UNIT ADMINISTRATOR/MGR:	**JOB TITLE:**	
ADDRESS:		**FIRST DAY ABSENT:**
PHONE # (HOME):	**POSTAL CODE:**	

EMPLOYEE CONSENT

I hereby authorize Dr._____ to disclose to the Occupational Health and Safety Department (OH&SD) information regarding my current injury, illness and/or treatment plan and any necessary further clarification regarding my fitness to perform the duties of my job (the "information").
I authorize the Occupational Health Physician / Nurse/ Ability management specialist/ Rehabilitation specialist to contact my physician to clarify information as necessary.
I understand that the information will be disclosed to OH&SD for the purposes of eligibility for benefits, and/or supporting my needs for accommodation, and purposes related to or incidental thereto. I understand that the medical information will be kept in my confidential OH&SD file and that medical information will not be disclosed to a third party without my consent, except where otherwise required or permitted by law.
I understand that, for the purpose of eligibility for benefits, 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 Human Resources department of NYGH. This consent will remain in effect until I return to full duties and hours of my position, or until I revoke it in writing.

Signature of Employee: X _____ **Date:**_____

ILLNESS / INJURY INFORMATION: to be completed by treating physician

Nature of Illness:	**Date of Onset:**
Signs / Symptoms:	
Communicable Disease? ☐ YES. Type of illness: _____ **; ☐ NO**	
Date first assessed:	**Date last assessed:**
Did this injury arise out of employment at North York General Hospital? ☐ YES ☐ NO WSIB #:	
Is this a recurring condition? ☐ YES ☐ NO	
Has referral been made to a specialist? ☐ YES ☐ NO	***Please specify specialties:***
Treatment plan / dates	
Please attach any supporting documentation (e.g. consult notes) as you see fit.	

Cont'd

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EMPLOYEE NAME:

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

☐ **Fit to return to FULL duties on: (Date)_____**
☐ **Fit to return to Transitional duties on: (Date)** _____

Please complete restrictions below and specify **Expected duration of limitations**: _____

WALKING	O full abilities; O up to 15 min; O up to 30 min; O other _____
STANDING	O full abilities; O up to 15 min; O up to 30 min; O other _____
SITTING	O full abilities; O up to 15 min; O up to 30min; O other _____
LIFTING (floor to waist)	O full abilities; O up to 5kg; O up to 10 kg; O up to 15kg; O other _____
Frequency of lifting (floor to waist) can be:	O minimal (<10%) O occasional (11 – 34%) O frequent (35 – 66%)
Lifting (waist to shoulder)	O full abilities; O up to 5kg; O up to 10 kg; O up to 15kg; O other _____
Frequency of lifting (waist to shoulder) can be:	O minimal (<10%) O occasional (11 – 34%) O frequent (35 – 66%)
LIFTING (overhead)	O full abilities; O up to 5kg; O up to 10 kg; O up to 15kg; O other _____
Frequency of lifting (overhead)can be:	O minimal (<10%) O occasional (11 – 34%) O frequent (35 – 66%)
PUSHING / PULLING	O full abilities; O up to 7kg; O up to 14kg; O up to 25kg; O other _____
Frequency of pushing/pulling can be:	O minimal (<10%) O occasional (11 – 34%) O frequent (35 – 66%)
Stair climbing	O full abilities; O up to 5 steps; O up to 10 steps; O other _____
Ladder climbing	O full abilities; O up to 3 steps; O up to 6 steps; O other _____
GRIPPING	O minimal (<10%) O occasional (11 – 34%) O frequent (35 – 66%)
REACHING ABOVE SHOULDER can be:	O minimal (<10%) O occasional (11 – 34%) O frequent (35 – 66%)
REACHING BELOW SHOULDER can be:	O minimal (<10%) O occasional (11 – 34%) O frequent (35 – 66%)
BENDING/TWISTING of _____	O minimal (<10%) O occasional (11 – 34%) O frequent (35 – 66%)
SHIFT RESTRICTIONS	O Regular hours; O 4 hours; O 6 hours; O other _____
COGNITIVE (*if applicable*)	**Coherent** O YES O NO **Judgment** O GOOD O ADEQUATE O POOR **Concentration** O GOOD O ADEQUATE O POOR **Can this person work** O Independently? O With supervision? O With assistance?

☐ **Unfit to work** (i.e., **TOTALLY DISABLED**, meaning hospitalized or otherwise incapable of performing acts of daily living). **Expected duration of TOTAL disability**: _____ **Next assessment date:** _____

*****Please state reasons why this 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 legislative requirements for accommodation:**_____

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