

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.

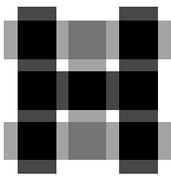
I understand that, for the purpose of eligibility for benefits, facilitating my return to work, information related to my ability to return to work and my accommodation requirements will be shared with my manager/supervisor and with Human Resources department of NYGH. This consent will remain in effect 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? <input type="checkbox"/> YES. Type of illness: _____ ; <input type="checkbox"/> NO			
Date first assessed:		Date last assessed:	
Did this injury arise out of employment at North York General Hospital? <input type="checkbox"/> YES <input type="checkbox"/> NO WSIB #:			
Is this a recurring condition? <input type="checkbox"/> YES <input type="checkbox"/> NO			
Has referral been made to a specialist? <input type="checkbox"/> YES <input type="checkbox"/> NO		<i>Please specify specialties:</i>	
Treatment plan / dates			
<i>Please attach any supporting documentation (e.g. consult notes) as you see fit.</i>			

Cont'd



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