

# Medical Certificate – Form B

(To be completed by ONA members hired prior to January 1, 2006) – 1980 HOODIP

## Section A : Employee Information & Consent – To be Completed by the Employee

Name (Last, First): \_\_\_\_\_

Site:  General  Birchmount  Centenary  Satellite \_\_\_\_\_

Dept/Unit: \_\_\_\_\_ Occupation: \_\_\_\_\_ Manager: \_\_\_\_\_

Employee ID: \_\_\_\_\_  Full Time  Part Time

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

First Day Absent (dd/mm/yy): \_\_\_\_\_ Telephone: \_\_\_\_\_

Personal Email Address (optional): \_\_\_\_\_

I hereby authorize the practitioner, by completing and signing this form, to fill out and release all sections of this form pertaining to my current or recent medical condition, to my employer's Workplace Health & Safety Department (WHS). This information provided is for the purpose of determining my fitness to work, and/or the need for any accommodations in my workplace, and/or substantiating my absence due to illness or injury, and/or eligibility for benefits. I also consent for my practitioner to respond to any inquiry from the WHS department for these purposes only, in regards to the clarity of the contents of this form. I understand that I will be informed when any information or request needs to be made to my practitioner. All medical information received will be kept in strict confidence in the employee's medical file within the Workplace Health & Safety Department.

Employee Signature: \_\_\_\_\_ Date (dd/mm/yy): \_\_\_\_\_

## Section B : Medical Certificate – (To be Completed by ONLY the practitioner)

*Please complete this form to assist us in determining your patient's eligibility for sick leave due to total disability. Total disability (as per HOODIP sick benefits plan) refers to medically determinable physical or mental impairment due to injury or illness that prevents your patient from working. Please note that if your patient is not able to perform the regular duties of his/her job, we are able to provide modified work, in most cases. Please complete **all sections** and return this form promptly to ensure continuation of wages and/or benefits for your patient.*

**Nature of Illness/Injury:** (i.e. a general statement of a person's illness or injury)

\_\_\_\_\_  
\_\_\_\_\_

A communicable disease potentially reportable to Public Health  Workplace Injury (WSIB)

A surgical matter:  Yes  No

Hospitalized from (dd/mm/yy) \_\_\_\_\_ to (dd/mm/yy) \_\_\_\_\_

\*Please complete **ONLY** if employee is experiencing **infectious** symptoms and/or has a communicable disease. In order to comply with the **Regulation 965, Section 4 of the Public Hospitals Act**, please complete the following if the employee is suffering from an infectious or communicable illness:

**What is the infectious diagnosis and sign/symptom(s)?**

---

**When did the initial symptoms start?**

---

**When was the employee first medically assessed?**

---

**What is the prescribed treatment, start date, and duration?**

---

**When is it expected that the employee should be non-contagious for a return to work?**

---

1. **Date of first visit for current health issue (dd/mm/yy):** \_\_\_\_\_

Date of most recent visit (dd/mm/yy): \_\_\_\_\_

2. **I confirm that the patient is participating in active treatment that I have prescribed**  Yes  No

If **yes**, date treatment started (dd/mm/yy): \_\_\_\_\_

3. **Is the patient presently under the care of a specialist?**  Yes  No

If **no**, has a referral occurred?  Yes  No  NA

4. **At this time, what is the prognosis for a complete recovery?**  Poor  Guarded  Good

**Section C: Recommended Physical Capabilities: To be Completed by Physician/Practitioner ONLY if the employee is returning to work with restrictions**

Please list the employee's "**current**" restrictions/limitations:

Select appropriate body part/system	Restriction/Limitation	Comments
Shoulder/Arm/Forearm	<input type="checkbox"/> No work above shoulder height with affected arm(s) <input type="checkbox"/> Limited reaching with affected arm(s) less than ___ cm <input type="checkbox"/> Limited reaching with affected arm(s) less than ___ minutes <input type="checkbox"/> Limited push/pull with affected arm(s) to less than ___ kgs	

Select appropriate body part/ system	Restriction/Limitation	Comments
Hand/Finger	<input type="checkbox"/> Limited grip/grasp with affected hand(s) to less than ___ minutes <input type="checkbox"/> Limited forceful grip/grasp with affected hand(s) <input type="checkbox"/> No use of affected hand(s)	
Lifting	<input type="checkbox"/> No lifting floor to waist more than ___ kgs <input type="checkbox"/> No lifting waist to shoulder more than ___ kgs	
Leg/Knee/Ankle/Foot	<input type="checkbox"/> Limit sitting to less than ___ hours/day <input type="checkbox"/> Limit standing to less than ___ hours/day <input type="checkbox"/> Limit walking to less than ___ hours/day <input type="checkbox"/> Limit squat/knee to less than ___ minutes at a time <input type="checkbox"/> No squatting/kneeling <input type="checkbox"/> No stair climbing <input type="checkbox"/> No ladder climbing	<b>In terms of sitting, standing and/or walking, please also note:</b>  Interval Duration ___ minutes Break ___ minutes
Back/Neck	<input type="checkbox"/> Limited twisting <input type="checkbox"/> Limited bending forward to less than 45° <input type="checkbox"/> Limited bending forward to less than 90° <input type="checkbox"/> Limited neck flexion to ___	
Cognitive/Psychological	<input type="checkbox"/> Problems relating to peers/clients <input type="checkbox"/> Difficulties performing simple and/or repetitive tasks <input type="checkbox"/> Problems maintaining focus/concentration <input type="checkbox"/> Reduced energy and pace <input type="checkbox"/> Problem responding appropriately to supervision/ management	
Other	<input type="checkbox"/> Restrictions related to medication (specify) <input type="checkbox"/> Restrictions related to cardiovascular: <input type="checkbox"/> Class 1 <input type="checkbox"/> Class 2 <input type="checkbox"/> Class 3 <input type="checkbox"/> Class 4 <input type="checkbox"/> _____	

By signing below I verify that, based on my assessment and objective medical evidence, the patient has been:

- Totally disabled** (unable to perform any job duties) from (dd/mm/yy) \_\_\_\_\_ with an expected return to:  
**Modified duties on (dd/mm/yy) \_\_\_\_\_ or Regular duties on (dd/mm/yy) \_\_\_\_\_**
- Partially disabled** (able to perform some job duties) from (dd/mm/yy) \_\_\_\_\_ with an expected return to regular duties (dd/mm/yy) \_\_\_\_\_

Planned follow-up date (dd/mm/yy): \_\_\_\_\_

Employee Name: \_\_\_\_\_

## Section D : Attending Practitioner Contact Information & Fees

Practitioner's Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: (dd/mm/yy) \_\_\_\_\_

\_\_\_\_\_  
Practitioner's Stamp

**FAX: 416-431-8265 or email: [occhealth@shn.ca](mailto:occhealth@shn.ca)**

### Dear Attending Health Care Practitioner:

Scarborough Health Network (SHN) recognizes our employees as our most valuable resource. As such, we offer a comprehensive sick leave program, temporary transitional modified duties and/or accommodation, if necessary.

To assist the organization in applying these supports, the attached SHN Medical Certificate (MC) is required.

**We rely on the timely receipt of medical documentation that outlines our employee's functional abilities. As the treating practitioner, your completion of all sections of this form is required in order to substantiate our employee's sick leave (which may include payment of sick benefits) and/or to support the need for Gradual Return to Work (GRTW) or accommodation, if necessary.**

If medically necessary, temporary GRTW is provided for our employees to support the successful return to full regular duties. GRTW must be goal oriented, time limited (typically four to six weeks in duration), progressive in nature and based on medically supported functional abilities. GRTW may include modifications to his/her regular hours and/or duties or by placement in other positions more suited to his/her functional abilities.

It has been shown that early intervention and return to the workplace may reduce overall recovery times and limit the negative impact of a prolonged absence.

I thank you for your support and care of our valued employee. If you have any questions or concerns, please feel free to contact us.

Respectfully yours,

Workplace Health and Safety Department  
**Scarborough Health Network**