Medical Certificate – Form A

(To be completed by ALL STAFF: except ONA members hired prior to January 1, 2006) – 1992 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: _____ **Shift Worker:** ❒ No ❒ Yes ❒ 8 ❒ 10 ❒ 12

Address: _____ **City:** _____ **Postal Code:** _____

First Day Absent (dd/mm/yy): _____ **Telephone:** _____

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 dept. for these purposes only, in regards to the clarity of the contents of this form. Any information or requests to the doctor will be provided to the worker at the time of the request. 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 r*eportable to Public Health* ❒ MVA ❒ Workplace Injury (WSIB)

❒ A surgical matter: **OHIP covered** ❒ Yes ❒ No

❒ Hospitalized from **(**dd/mm/yy) _____ to **(**dd/mm/yy) _____

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

Date of most recent Visit (dd/mm/yy): _____

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

2) **I confirm that the patient is participating in active treatment that I have prescribed** ❒ Yes ❒ No
If yes, please describe treatment provided and the treatment plan:

_____

_____

3) **Is the patient presently under the care of a specialist?** ❒ Yes ❒ No
If no, has a referral occurred? ❒ Yes ❒ No ❒ N/A

4) **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) _____

Employee Name: _____

Section C: RECOMMENDED PHYSICAL CAPABILITIES:
To be Completed by Physician/Practitioner ONLY IF the employee is returning to work with restrictions

Functional Abilities

Walk	☐ 0 – 15 mins.	☐ 15 – 30 mins.	☐ 30 – 60 mins.		
Sit	☐ 0 – 15 mins.	☐ 15 – 30 mins.	☐ 30 – 60 mins.		
Stand	☐ 0 – 15 mins.	☐ 15 – 30 mins.	☐ 30 – 60 mins.		
Lift	Medium (21-50lbs)	Light (11-20lbs)	Sed. (0-10lbs)		**Please note: Maximum safe lifting limit for patient handling is ≤ 35lbs**
Push/Pull	Medium (21-50lbs)	Light (11-20lbs)	Sed. (0-10lbs)		
Carry	☐ Both Hands	☐ Limited ability	☐ Left Hand	☐ None	Max. Weight:
Fine Finger	☐ Both Hands	☐ Limited ability	☐ Left Hand	☐ None	Max. Weight:
Dominant Hand	☐ Both Hands	☐ Limited ability	☐ Left Hand	☐ None	Max. Weight:
Stair Climb	☐ Full Abilities	☐ Limited ability	☐ Cannot perform		
Ladder Climb	☐ Full Abilities	☐ Limited ability	☐ Cannot perform		
Pushing/Pulling	☐ Full Abilities	☐ Limited ability	☐ Cannot perform		
Bending	☐ Full Abilities	☐ Limited ability	☐ Cannot perform		
Crouching/Kneeling	☐ Full Abilities	☐ Limited ability	☐ Cannot perform		
Driving	☐ Full Abilities	☐ Limited ability	☐ Cannot perform		
Repetitive Motion	☐ Full Abilities	☐ Limited ability	☐ Cannot perform		

Cognitive Capabilities – If applicable, please indicate limitations in cognitive function:

Memory	☐ Normal	☐ Some Concerns	☐ Signifcant Impairment
Judgment	☐ Normal	☐ Some concerns	☐ Signifcant Impairment
Concentration	☐ Normal	☐ Some concerns	☐ Signifcant Impairment
This Individual Can Work	☐ Independent	☐ Supervision	☐ With Assistance

Section D: Attending Practitioner Contact Information & Fees

Fees for Completion of Medical Certificate: Payment for completion is per SHN policy or collective agreement and OMA Fee Schedule. **It is the responsibility of the patient/employee to pay the practitioner for any costs incurred for completion of this form**. Please provide the patient/employee the **original receipt and proof of payment within 90 days** for reimbursement by the hospital.

Practitioner's Name:_____

Professional Designation/Specialty (e.g. MD, Chiro, Physio, Specialist): _____

Phone: _____ **Fax:**_____

Signature: _____

Date: (dd/mm/yy) _____

Practitioner's Stamp

ONCE COMPLETED PLEASE RETURN TO: WORKPLACE HEALTH & SAFETY DEPARTMENT

BIRCHMOUNT HOSPITAL	GENERAL HOSPITAL	CENTENARY HOSPITAL
3030 Birchmount Road Scarborough, ON M1W 3W3 T: 416-495-2473	3050 Lawrence Avenue East Scarborough, ON M1P 2V5 T: 416-431-8137	2867 Ellesmere Road Scarborough, ON M1E 4B9 T: 416-284-8131 X 7314

FAX: 416-431-8265 or email: 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 employee 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