SHN
SCARBOROUGH HEALTH NETWORK

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 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 **ONLY by** 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: **OHIP covered** ☐ 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): ______________________

   In addition, please describe the 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 ☐ 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	☐ No work above shoulder height with affected arm(s) ☐ Limited reaching with affected arm(s) less than____cm ☐ Limited reaching with affected arm(s) less than____minutes ☐ Limited push/pull with affected arm(s) to less than____kgs	

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

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

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