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: _____ ☐ 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 applicable 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 – diagnosis not required)

_____

_____

☐ A communicable disease potentially reportable to Public Health? ☐ Yes ☐ No
If yes, has it been reported. ☐ Yes ☐ No

☐ Workplace Injury (WSIB) ☐ Yes ☐ No

☐ A surgical matter: ☐ Yes ☐ No

☐ 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): _____

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. In addition, please describe the treatment provided and the treatment plan (do not include names of medications)

   _____

4. Is the patient presently under the care of a specialist? ☐ Yes ☐ No

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

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

6. By signing below (Section D) I verify that, based on my assessment and objective medical evidence, the patient is

   ☐ **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) _____. **If so, please complete Section C**

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

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

Please indicate **RESTRICTIONS** that may apply. Include details below.

Walking:	Standing:	Sitting:
☐ Full Abilities ☐ Up to 100 meters ☐ 100 - 200 meters ☐ Other (please specify):	☐ Full Abilities ☐ Up to 15 minutes ☐ 15 - 30 minutes ☐ Other (please specify):	☐ Full Abilities ☐ Up to 30 minutes ☐ 30 minutes – 1 hour ☐ Other (please specify):

Lifting from Floor to Waist:	Lifting from Waist to Shoulder:
☐ Full Abilities ☐ Up to 5 kilograms ☐ 5 - 10 kilograms ☐ Other (please specify):	☐ Full Abilities ☐ Up to 5 kilograms ☐ 5 - 10 kilograms ☐ Other (please specify):

Please indicate **RESTRICTIONS** that may apply. Include details below.

Bending/Twisting/ Repetitive Movement:	
☐ No Limitations ☐ Limited (please specify) ☐ No Bending/Twisting/Repetitive Movement of (please specify)	☐ Potential side effects from medications related to this injury/illness (Do not include names of medications):

Work at or Above Shoulder:	Limited Use of Hands:	Limited Pushing/Pulling with:
☐ No Limitations ☐ Work at or Above Shoulder level ☐ Please Specify Weight:	☐ Gripping ☐ Pinching ☐ Other (please specify) ☐ Left ☐ Right ☐ Both	☐ Left Arm ☐ Right Arm ☐ Please Specify Weight:

Please indicate **LIMITATIONS TO COGNITIVE FUNCTIONS** that may apply.

Memory	☐ Normal	☐ Some Concerns	☐ Significant Impairment
Judgement	☐ Normal	☐ Some Concerns	☐ Significant Impairment
Concentration	☐ Normal	☐ Some Concerns	☐ Significant 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 for potential reimbursement by the hospital.

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 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. SHN will endeavour to identify a safe and suitable assignment based on the restrictions or limitations listed.

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