ST. JOSEPH'S CARE GROUP

Short-Term Disability Package For Employees

What do I do when I am going on a sick leave (non-WSIB)?

- Take this package to your Doctor, Nurse Practitioner (NP), or Physician Assistant (PA)
- Obtain the **Attending Physician Statement Form** to be filled out by a medical practitioner.
- **** If you are an RN hired before January 1, 2006 you will be required to have the Attending Practitioner's Form filled out ****
- Call the manager/supervisor, staffing and the occupational health nurse
- Call Human Resources if you have questions about your sick leave benefits 807-343-4311
- Provide ongoing updates to the manager/supervisor about the length of your absence
- Provide ongoing updates to the occupational health nurse after follow-up appointments and submit an updated doctor's note if you are unable to return on the original return to work date

What do I do when I am able to return to work?

- Obtain supporting medical (doctor's note that states you can return to full duties and the date you are able to return)
- Submit the medical note to Occupational Health
- Contact the occupational health nurse and your manager/supervisor
- The occupational health nurse will send a notification to the manager and staffing including your return to work date specified by your medical practitioner

What do I do when I require a return to work plan?

- Obtain a Functional Abilities Form (FAF) from a registered health care practitioner (Example: Doctor, NP, Physiotherapist, Occupational Therapist, Chiropractor)
- Submit the completed FAF form to Occupational Health
- The Occupational Health Nurse will contact you once the FAF has been received and book a return to work meeting with you, the manager/supervisor, union representative and Occupational Health Nurse

How can I submit my forms to Occupational Health?

- Email: SJCG.OccHealth@tbh.net
- Fax: 807-346-2353
- Bringing a copy to Occupational Health, Safety & Wellness department located at 35 Algoma St, Level 0, Room B083

The Occupational Health Nurse is available at 346-2341

ST. JOSEPH'S CARE GROUP

ATTENDING PHYSICIAN'S STATEMENT

Section A **Employee Information:** *(to be completed by employee)*

Name: _____ Job Title: _____

Address: _____ City: _____

Postal Code: _____ Email: _____

Primary Phone #: _____

LAST DAY WORKED: _____ **FIRST MISSED SHIFT:** _____

Section B **Consent:** (to *be completed by employee)*

I authorize the physician/practitioner to disclose information to Occupational Health & Wellness, St. Joseph's Care Group regarding my medical condition as it relates to my current absence from work by completing Sections C and D (below) for the purposes of validating and managing my claim for a medical leave of absence, as it relates to my fitness for work.

I understand that Occupational Health & Wellness, St. Joseph's Care Group will keep my medical information confidential but for the purpose of facilitating my return to work. I consent to allow Occupational Health & Wellness, St. Joseph's Care Group to relate my claim status, my absence duration and my ability to return to work with or without restrictions to my employer. I also consent to allow Occupational Health & Wellness, St. Joseph's Care Group to share nonmedical information with my employer as it relates to my current absence for the purpose of facilitating my return to work (if applicable).

A photocopy of this authorization is as valid as the original.

_____ _____

Signature Date

Section C *(to be completed by qualified medical doctor or qualified mental health professional)*

Date first assessed to be totally disabled from all duties: _____

Expected period of absence (total disability): _____

General nature of illness or injury
(without disclosure of diagnosis): _____

Is this absence work related: ☐ Yes ☐ No

Employee is under active treatment: ☐ Yes ☐ No

Please describe treatment provided and plan: _____

Anticipated return to work date: _____

Complete recovery expected: ☐ Yes ☐ No

PLEASE TURN OVER >

Section D

Employee Name: _____

We support early safe and timely return to work. We are committed to providing modified duties to support the recovery process. Please fully complete the appropriate box below.

☐ **Fit to return to full duties**:

Date:

☐ **Employee unfit to work:** Please describe the functional impairment that is preventing this employee from performing **any and all work**:

Duration: Reassessment Date:

☐ **Employee fit for Modified Work:** Please indicate specific functional limitations:

Duration: Reassessment Date:

By affixing my signature below, I certify that I am a qualified medical doctor or a qualified mental health professional and that I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.

PHYSICIAN'S NAME: (Please Print) _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

SIGNATURE: _____ **DATE:** _____

Return form by confidential fax, email or mail to Occupational Health & Wellness.

Confidential Fax #: 807-346-2353 Email : sjcg.occhealth@tbh.net

Address: St. Joseph's Hospital, 35 Algoma Street North , P.O. Box 3251, Thunder Bay, Ontario P7B 5G7

Questions about this collection should be directed to the contact for Freedom of Information, 35 N. Algoma St., N., Thunder Bay, Ontario, P7B 5G7. Phone (807) 343-2454.

ST. JOSEPH'S CARE GROUP

ATTENDING PRACTITIONER'S STATEMENT

ONA SJ Hospital Employees Hired Before January 1, 2006

Section A **Employee Information:** *(to be completed by employee)*

Name: _____ Job Title: _____

Address: _____ City: _____

Postal Code: _____ Email: _____

Primary Phone #: _____

LAST DAY WORKED: _____ **FIRST MISSED SHIFT:** _____

Section B **Consent:** (to *be completed by employee)*

I authorize the physician/practitioner to disclose information to Occupational Health & Wellness, St. Joseph's Care Group regarding my medical condition as it relates to my current absence from work by completing Sections C and D (below) for the purposes of validating and managing my claim for a medical leave of absence, as it relates to my fitness for work.

I understand that Occupational Health & Wellness, St. Joseph's Care Group will keep my medical information confidential but for the purpose of facilitating my return to work. I consent to allow Occupational Health & Wellness, St. Joseph's Care Group to relate my claim status, my absence duration and my ability to return to work with or without restrictions to my employer. I also consent to allow Occupational Health & Wellness, St. Joseph's Care Group to share nonmedical information with my employer as it relates to my current absence for the purpose of facilitating my return to work (if applicable).

A photocopy of this authorization is as valid as the original.

_____ _____

Signature Date

Section C *(to be completed by qualified medical doctor or qualified mental health professional)*

Date first assessed to be totally disabled from all duties: _____

Expected period of absence (total disability): _____

General nature of illness or injury
(without disclosure of diagnosis): _____

Is this absence work related: ☐ Yes ☐ No

Employee is under active treatment: ☐ Yes ☐ No

Anticipated return to work date: _____

Complete recovery expected: ☐ Yes ☐ No

PLEASE TURN OVER >

Section D

Employee Name: _____

We support early safe and timely return to work. We are committed to providing modified duties to support the recovery process. Please fully complete the appropriate box below.

☐ **Fit to return to full duties**:

Date:

☐ **Employee unfit to work:** Please describe the functional impairment that is preventing this employee from performing **any and all work**:

Duration: Reassessment Date:

☐ **Employee fit for Modified Work:** Please indicate specific functional limitations:

Duration: Reassessment Date:

By affixing my signature below, I certify that I am a qualified medical doctor or a qualified mental health professional and that I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.

PHYSICIAN'S NAME: (Please Print) _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

SIGNATURE: _____ **DATE:** _____

Return form by confidential fax, email or mail to Occupational Health & Wellness.

Confidential Fax #: 807-346-2353 Email : *sjcg.occhealth@tbh.net*

Address: St. Joseph's Hospital, 35 Algoma Street North , P.O. Box 3251, Thunder Bay, Ontario P7B 5G7

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ST. JOSEPH'S CARE GROUP

Functional Abilities Form for Timely Return to Work

Employee Name: _____ Phone #: _____ D.O.B. _____

Job Title: _____ Manager: _____

Authorization for Release of Information:
I authorize the physician/practitioner to give documentation of my current medical condition to Occupational Health Services, St. Joseph's Care Group strictly for the purposes of validating my claim for total disability and managing my medical absence. I consent to allow Occupational Health & Wellness to provide information related to my fitness for work and any accommodation needs to my manager/supervisor/Human Resources and Union Representative(if applicable). A photocopy of this authorization is as valid as the original.

Employee Signature: _____ Date: _____

Nature of Illness/Injury: _____

Please complete where limitations are recommended (only where applicable):

A. Walking/Standing/Sitting					
	Unable	< 15 minutes	15 - 30	30 – 60	60 minutes
Walking					
Standing					
Sitting					
Squatting/Kneeling					

B. Lifting/Pushing/Pulling				
	Unable	*Minimal (<10%)*	*Occasional (11 0 34%)*	*Frequent (35 – 66%)*
Lifting Floor to Waist				
Sedentary/Light (<7 kg/ 15 lb)				
Medium (<14 kg/ 30 lb)				
Heavy (<25 kg/ 55 lb)				
Lifting Waist to Shoulder				
Sedentary/Light (<7 kg/ 15 lb)				
Medium (<14 kg/ 30 lb)				
Heavy (<25 kg/ 55 lb)				
Lifting Above the Shoulder				
Sedentary/Light (<7 kg/ 15 lb)				
Medium (<14 kg/ 30 lb)				
Heavy (<25 kg/ 55 lb)				
Pushing/Pulling				
Sedentary/Light (<7 kg/ 15 lb)				
Medium (<14 kg/ 30 lb)				
Heavy (<25 kg/ 55 lb)				

Please Turn Over

Employee Name: _____

C. Other Physical Restrictions			
	Minimal (<10%)	*Occasional (11 0 34%)*	*Frequent (35 – 66%)*
Gripping			
Keyboarding			
Carrying			
Reaching overhead			
Bending/Twisting (cervical/ lumbar)			
Climbing stairs/ladders			

D. Other Restrictions (if applicable):							
Shift/Hours Restrictions (please specify):							
Repetitive Movement/Use of:							
Chemical/Environmental Exposure to:							
Restrictions Related to Medications:							
Exposure to Vibrations: high frequency		low frequency					
Operating a Motor Vehicle: No Limitations		Limitations reported to the Ministry of Transportation Yes		No			
Would utilizing public transit be a feasible option? Yes		No					

E. Cognitive Restrictions (if applicable):							
No Limitations							
Coherent Yes		No					
Concentration Good		Adequate		Poor			
Judgment Good		Adequate		Poor			
Can this person work: Independently?		With Supervision?		With Assistance?			
Additional Comments:							

Date of Next Assessment:	**Date RTW Modified Work:**
Estimated Duration of Limitations:	**Date RTW Regular Job:**

B*y completing this Functional Abilities Form, the information contained herein will become part of the employee's medical file.* ***Modified work is available.*** *Please have the employee return this completed form to Occupational Health & Wellness via confidential fax number (807) 346-2353 immediately.*

Health Professional Name: _____ Health Profession: _____

Date of Next Appointment: _____ Telephone: _____

Full Address: _____ City/Town: _____ Prov.: _____

Signature: _____ Date: _____

St. Joseph's Care Group, 35 N. Algoma Street, P.O. Box 3251, Thunder Bay, ON P7B 5G7 Telephone 807-346-2341 Fax 807-346-2353

Questions about this collection should be directed to the contact for Freedom of Information, 35 N. Algoma St., N., Thunder Bay, Ontario, P7B 5G7. Phone (807) 343-2454.