ATTENDING PHYSICIAN'S STATEMENT

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

Name:

Primary Phone #: ____________________________

Address:

City: ____________________________

Email Address: ____________________________

Postal Code: ____________________________

____

Job Title: ____________________________

LAST DAY WORKED:____________________

FIRST MISSED SHIFT: ____________________

Section B **Consent:** (t*o* ***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

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.