



## ATTENDING PRACTITIONER'S STATEMENT

ONA SJ Hospital Employees hired before January 1, 2006

### 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: *(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

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 : [OccHealth@tbh.net](mailto: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 Freedom of Information Coordinator,  
580 Algoma St. N., Thunder Bay, Ontario, P7B 5G4, Phone: (807) 346-5238, E-mail: [foi-sjcg@tbh.net](mailto:foi-sjcg@tbh.net)