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

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.