The Ottawa Hospital | L'Hôpital d'Ottawa

ATTENDING PRACTITIONER'S STATEMENT REPORT

In application for sick leave benefits or to support of work absence, please ask your physician to complete section 2 of this form.
This information is vital to ensure eligibility to benefits during absence from work.

☐ **Civic Campus**
1053 Carling Avenue
Ottawa, ON K1Y 4E9
Fax: 761-4162
Tel: 798-5555 x14161

☐ **General Campus**
501 Smyth Road
Ottawa, ON K1H 8L6
Fax: 737-8912
Tel: 737-8899 x78391

☐ **Riverside Campus**
1967 Riverside Drive
Ottawa, ON K1H 7W9
Fax: 738-8260
Tel: 738-8400 x88250

Or by e-mail marked "Confidential" to: OccupationalHealth@toh.ca

If your illness or injury is a result of a workplace incident, **do not use this form**.

SECTION 1: To be completed by the employee		
Last name	First name	Date of birth (YYYY/MM/DD)
Date of injury / illness (YYYY/MM/DD)	First date of absence (YYYY/MM/DD)	
Employment status ☐FT ☐PT ☐Casual	Physician's name	

Employee Consent
I authorize the physician who has provided care to me during my current injury/illness to complete this form and communicate as necessary with Occupational Health and Wellness (OHW) at The Ottawa Hospital (TOH) to clarify information about my condition and ability to perform my work tasks. I have read and agree to abide by my responsibilities outlined in the medical leave policy (No. 00264)

I agree to provide OHW with updates concerning my prognosis and my abilities as they relate to my job tasks. This initial report will be provided to OHW within 48 hours of any medical assessment. If I am aware of any delays in obtaining the information requested, I agree to inform OHW promptly and to facilitate ongoing communication to assist in my successful return to work. I understand that failure to sign this consent may impact access to sick leave benefits.

This consent is granted on the understanding and condition that I will be advised in advance by the OHW each time that it will be contacting my physician in relation to this current absence from work, as well as the reason such contact is being made. I reserve the right to deny this request and understand that failure to consent to this request may impact access to sick leave benefits.

Employee signature:	Date (YYYY/MM/DD)

SECTION 2: To be completed by the attending physician	
First date of assessment (YYYY/MM/DD)	Next date of assessment, if applicable (YYYY/MM/DD)

Nature (but not diagnosis) of the current injury/illness causing absence from work (e.g., communicable disease, musculoskeletal injury, blood pressure, etc). If more than one, please indicate.

How was the medical conclusion reached (diagnostic or other objective tests)?
_____
Is this a provincially insurance paid procedure? Ex: OHIP ☐Y ☐N
Is this a dental procedure? ☐Y ☐N If yes, is it medically required? ☐Y ☐N

Is the employee totally disabled (as per HOODIP) as a result of the illness/injury from performing duties of their occupation? ☐Y ☐N

Is the employee able to return to regular duties? ☐Y ☐N If yes, please indicate date of return (YYYY/MM/DD):_____

Has the employee missed work for the same or similar condition in the past? ☐Y ☐N

Is the employee actively participating in the recommended treatment plan? ☐Y ☐N
Please identify the type and frequency of treatment:

Is the employee under treatment which may impair his/her judgement or ability to work safely? ☐Y ☐N

TOH supports a modified work program that promotes an employee's safe and healthy return to work (e.g., progressive gradual return to work hours; modified duties). (please note that additional workers are available to support employees requiring modified work, if needed)

If the employee cannot return to full duties, can the employee return to work with restrictions and/or modified duties? ☐Y ☐N
If yes, please complete section 3

What is the expected duration for?

modified duties/hours? _____

and/or restrictions? _____

SECTION 3 To be completed by the attending physician

PHYSICAL ABILITIES		<1 hr	1-2 hrs	2-4 hrs	5-6 hrs	>6 hrs
Sitting	☐ Full abilities	☐	☐	☐	☐	☐
Standing	☐ Full abilities	☐	☐	☐	☐	☐
Walking	☐ Full abilities	☐	☐	☐	☐	☐
Stair Climbing	☐ Full abilities	☐	☐	☐	☐	☐
Movements	☐ Full abilities	☐ No sustained forward Flexion	☐ No overhead or extended arm reach	☐No bending or twisting	☐No repetitive or sustained use of:	☐ No work below waist
Pushing/Pulling **(kg)**	☐ Full abilities	☐No push	☐ No Pull			
Lifting/Lowering **(kg)**	☐ Full abilities	☐No lifting / lowering	☐<5	☐5-10	☐11-20	☐>20

COGNITIVE ABILITIES
If applicable, please comment

Thank you for completing this report.
The information provided will assist in giving this TOH employee the opportunity to return to work as soon as possible. Please note that medical leave benefits will be payable as soon as this form is received and accepted by OHW.

Attending physician name	Date (YYYY/MM/DD)	Signature
License number	Fax	Phone
Address		

Please note that any fee for the completion of this form is the responsibility of the employee.
TOH will reimburse the employee, as per the Medical Leave Policy.