The Ottawa Hospital | L'Hôpital d'Ottawa

Chronic Ongoing Condition Exclusion Form

Employee Information	
Name:	Department:
Employee ID:	Job Title:

Dear Doctor,

The Ottawa Hospital's Attendance Support Program (ASP) is designed to address and reduce excessive workplace absenteeism by providing employees with health and wellness supports. Placement on the program is triggered when an employee's absenteeism has exceeded the established attendance thresholds of 90 hours and/or eight (8) occurrences for full time employees, and 60 hours and/or six (6) occurrences for part time employees over a twelve (12) month period. Certain medical conditions can be excluded from the program. Medically recognized serious chronic ongoing conditions are excluded from our program. Your patient has indicated that some sick-related absences may qualify for such an exclusion from the ASP. **In order to determine whether this exclusion for this specific absence is warranted, further information is required, as outlined on the second page of this document.**

As per the Medical Leave Policy, a **medically established serious condition** is defined as a disease:

- Of long duration; and
- Generally slow progression; and
- Having a dangerous possible result; and
- Having had a specialist involved in consultation and / or management; and
- That impairs work functions in some significant manner.

Please send the completed form marked "Confidential" by fax to:

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

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Section A – Patient Authorization (to be completed by employee)

I authorize my treating, medically qualified health professional _____ to provide
(Name)
Occupational Health and Wellness with information regarding my illness and inability to work by completing the contents of Section B of this form. I understand that applying for exclusion is a voluntary process. I understand that The Ottawa Hospital will be using this information for the purposes of determining my eligibility for exclusion from the Attendance Support Program and that my personal health information will be kept private and confidential.

Employee signature: _____ Date: _____
DD / MM / YY

Section B – Treating Health Care Practitioner

In order to consider the employee's request, please provide details about the employee's condition by answering the questions below:

1. As per the above definition, does your patient have a medically recognized serious chronic ongoing condition?

   ☐ Yes What is the nature of this condition? _____

   ☐ No

2. Is the employee being seen by a specialist?

   ☐ Yes

   ☐ No

3. What is the current status of the medical condition?

   ☐ Condition is stable and no further improvements are expected

   ☐ Condition is stable and is expected to improve

   ☐ Condition is stable and is expected to deteriorate

   ☐ Condition is unstable and further treatment is required

4. **If** the condition is expected to deteriorate, what is the contributing factor?

   ☐ Natural progression of symptoms

   ☐ Comorbid medical conditions

   ☐ Non-adherence to recommended treatments

   ☐ Other: _____

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5. On which dates was your patient unable to attend work as related to this diagnosis?

_____

6. What restrictions and/or limitations can be implemented to assist the employee in attending work during a flare up or as a result of natural progression of the illness?

_____

7. How frequent are the occurrences that would impact the employee's attendance at work?

   Expected occurrences per month: _____ **OR** Expected occurrences per year: _____

8. What is the approximate duration (in days) of an absence related to an occurrence?

   Expected number of days of absence per occurrence: _____

9. Is the employee's attendance at work:

   ☐ Expected to improve? If yes, when: _____

   ☐ Expected to remain stable?

   ☐ Expected to worsen? If yes, please explain: _____

10. Is there anything else that may assist the employee in attending work on a regular basis?

_____

_____

I certify that the above information is accurately depicted as per my records to the best of my knowledge and expertise as it defines my patient's inability to attend work, as well as the prognosis thereof.

Physician's signature: _____ Date: _____
DD / MM / YY

Print name: _____ Phone number: ( ) _____