The Ottawa Hospital | L'Hôpital d'Ottawa

ATTENDING PRACTITIONER'S STATEMENT REPORT

SECTION 1: To be completed by the employee

Last Name | First Name | Date of Birth | ❑ Civic ❑ General ❑ Riverside

I hereby authorize _____ my attending practitioner who has provided care to me during my absence from work for the dates (from) _____ (to) _____ to release the medical information requested in the following questionnaire to Occupational Health Safety and Emergency Preparedness to explain my absence(s) in order to facilitate my return to work.

Employee signature: **Date:**

The Ottawa Hospital offers an Employee Assistance Program as well as an Early and Safe Return to Work Program to assist the reintegration of employees at work who are ill or have been injured. Hence, the information provided will be of assistance to ensure that employees are given the opportunity to return to work as soon as possible. We appreciate your prompt completion of this form

SECTION 2: To be completed by the attending practitioner

General Medical Information:

1. Is the employee taking medication which will impair his/her judgement or ability to operate equipment safely at work: ❑ Yes ❑ No
2. Is the employee receiving treatment from a specialist? ❑ Yes ❑ No ❑ being referred
3. Is the employee following the treatment plan: ❑ Yes ❑ No ❑ N/A
4. What are the components of the treatment plan?

_____

_____

_____

5. How frequent are the employee's appointments _____
6. How long do you expect the condition to last? _____
7. What limitations does the condition place on work life activities?

_____

_____

PROGNOSIS FOR SAFE RETURN TO WORK

Based on your assessment, the employee:

❑ Can return to work to modified duties/hours? Duration: from _____ to _____
Please provide details about the return to work plan, including restrictions if applicable, and hours of work:

_____

_____

_____

❑ Can return to regular duties and if so, indicate when: _____

❑ Is unable to return to work ❑ Expected date of return to work: _____

Please provide any other comment that would assist us in ensuring proper accommodation/ safe return to work.

_____

_____

_____

_____

May our Occupational Health Nurse/Physician contact you to discuss the above information? ❑ Yes ❑ No

Attending Practitioner information **(please print)**

Surname | Given name | Specialty

Address (Street, Apt, City) | Postal Code | Telephone | Email address | Fax

Signature | Date

Please note *that this form must be completed and returned to the Occupational Health Safety and Emergency Preparedness (OHSEP) promptly following employee's visit or their sick leave benefits may be affected. The Hospital will pay a maximum of $50.00 for this report. Please return the form to the OHSEP of the campus where your patient works. If required, call the OHSEP at the specific campus.*

OHSEP

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1053 Carling Avenue
Ottawa, Ontario K1Y 4E9
Fax.: 761-4162,
Tel.: 798-5555-14161

General Campus
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Ottawa, Ontario K1H 8L6
Fax.: 737-8912,
Tel.: 737-8899-78391

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1967 Riverside Drive
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