The Ottawa Hospital | L'Hôpital d'Ottawa

Attendance Support Program 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. Absences due to certain medical conditions can be excluded from the program. Your patient has indicated that some sick related absences may qualify for exclusion. **In order to determine whether this absence would qualify for exclusion, further information is required, as outlined on the second page of this document.**

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

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

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DD / MM / YY

Section B – Treating Health Care Practitioner

Please indicate with a check mark the type of absence that is being assessed for exclusion from the ASP by your patient:

☐ **One of the following communicable diseases (of the following list only as per the Ontario Health Association guidelines, as amended:**

- Acute chickenpox or disseminated zoster
- Conjunctivitis (either adenoviral or bacterial)
- Fever of 38°C or higher that is related to a communicable disease
- Herpetic whitlow
- Influenza (suspected or diagnosed)
- Group A Streptococcal Infections including streptococcal pharyngitis, impetigo or pyoderma
- Measles, Mumps, or Rubella
- Meningococcal disease including meningococcemia, meningococcal meningitis, or meningococcal pneumonia
- Pertussis
- Probable Enteric Bacterial Infection causing diarrhea and/or vomiting (with two or more incidents occurring within 24 hours)
- Scabies

Date(s) of Total Disability: _____ To _____
DD / MM / YY DD / MM / YY

☐ **An ongoing course of serious treatment that renders an individual debilitated and unable toperform activities of daily living during or following the treatment:**

Date(s) of Total Disability: _____ To _____
DD / MM / YY DD / MM / YY

Reasonable and customary amount of time expected to be off work: _____ days per month, OR _____ days per year.

☐ **A catastrophic event directly responsible for causing a marked impairment or an extreme impairment affecting activities of daily living and was under the doctor's care during the dates of absence:**

Date(s) of Total Disability: _____ To _____
DD / MM / YY DD / MM / YY

☐ **Medically necessary surgical interventions:**

Date(s) of Total Disability: _____ To _____
DD / MM / YY DD / MM / YY

☐ **A Chronic Ongoing Condition that has been documented and is approved by Occupational Health and is currently active**

Date(s) of Total Disability: _____ To _____
DD / MM / YY DD / MM / YY

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: ( ) _____