Lakeridge Health

Dear Attending Physician,

At Lakeridge Health, we are committed to providing early supports, offering modified or graduated return to work programs designed to ensure a safe and early return to work of employees who are recovering from injury or illness. As part of the Ontario Hospital Association's Hospitals of Ontario Disability Income Program (HOODIP), Lakeridge Health is required to follow established standards and policies. A Medical Certificate is required for any absence of three or more consecutive shifts, or when an employee is seeking or requires accommodation.

In order for Lakeridge Health employees to clarify accommodation requirements within the workplace or to qualify for sick benefits, the following must be met:

- Nature of illness must be indicated.
- Medical attention must be sought within a timely manner.
- Objective medical information, demonstrating total disability from work, for the period in question, submitted via the APR form, and completed in full to the satisfaction of the Abilities Management Case Manager, including restrictions and limitations, physical and/or cognitive.
- Active participation in treatment as prescribed by the treating practitioner.
- Duration of disability is consistent with standard recovery timelines as per best practice guidelines or accompanied by objective medical evidence which outlines complicating factors.

Please complete each section of the following form to assist us in determining your patient's eligibility for sick leave due to total disability. The employer will pay the clinic office directly, please do not charge the individual. The definition of total disability (as per HOODIP sick benefits plan) is "unable, due to injury or illness, to perform the regular duties pertaining to the occupation in which you participated immediately before becoming disabled. Please note that if your patient is not able to perform the regular duties of their job, we may be able to provide modified work. Please complete **all sections** and return this form promptly to ensure continuation of wages and/or benefits for your patient

You may fax your response to our confidential fax number at 905-743-5943 or email to OccHealthACMS@lh.ca . Invoices will be processed within 3 weeks of receipt, please do not send duplicates as this creates delays in payment. Thank you for your attention to this matter.

Should you have any questions/concerns, please contact the Team directly 905-576-8711 ext. 32865.

Thank you,

Abilities Team, People Services
Lakeridge Health
(T) 905-576-8711 ext 32865

Medical Certificate / APR

FAX: 905-743-5943
Email: OccHealthACMS@lh.ca

Lakeridge Health

Employee Information and Consent: **Status:** ☐ FT ☐ PT ☐ Temp ☐ Casual **Shift Worker:** ☐ NO ☐ YES ☐ 8 ☐ 10 ☐ 12

Name (Last, First): _____

Address: _____ **Telephone:** _____

First Day Absent: _____ **Department:** _____ **Occupation:** _____

Manager: _____ **Site:** _____ **Email:** _____

Employee Signature:	**Date:**

I hereby authorize the practitioner, by completing and signing this form, **to fill out and release *all sections* of this form pertaining to my current or recent medical condition**, to my employer's occupational health and abilities department and expert consultants as applicable. This information provided is for the purpose of determining my fitness to work and/or the need for any accommodations in my workplace and/or substantiating my absence due to illness or injury and/or eligibility for benefits. All medical information received will be kept in **strict confidence** in the employee's medical file within Occupational Health and Abilities.

Medical Certificate (to be completed ONLY by the practitioner):

*Please complete **all sections** and return this form promptly to ensure continuation of wages and/or benefits for your patient.*

1) **Type of Disability:**

☐ **Non-Occupational Injury/Illness** ☐ **Occupational Injury/Illness (WSIB – please complete a Form 8)** ☐ **Optional Medical Procedure**
☐ **A communicable disease potentially r*eportable to Public Health*** ☐ **MVA**
☐ **Recurrent condition** ☐ **A surgical matter; OHIP covered** ☐ YES ☐ NO
☐ **Mental Health condition w/ recognized diagnosis under the DSM-V** ☐ **Hospitalized/Bed Ridden from**_____ (dd/mm/yy) **to**_____ (dd/mm/yy)

2) **Nature of Illness/Injury:** (Disclosure of Diagnosis is not being requested)

3) **Date of first visit for current health issue:**_____ **Planned follow-up date:**_____

4) **Is patient participating in active treatment (i.e. medication/physiotherapy/counseling etc.)?** YES ☐ NO ☐ **Please provide details below:**

5) **Is the patient presently under the care of a specialist?** YES ☐ NO ☐ **If no**, has a referral occurred? YES ☐ date: _____ (dd/mm/yy) NO ☐ N/A ☐

6) ***By signing below, I verify that based on my assessment and objective medical evidence, the patient has been:***

☐ **Totally disabled** (unable to perform regular job duties) from _____ (dd/mm/yy) with an expected return to:

A) Modified duties on _____ (dd/mm/yy) **or B) Regular duties on** _____ (dd/mm/yy)

☐ **Partially disabled** (able to perform *some* job duties) from _____ (dd/mm/yy) with an expected return to regular duties on _____ (dd/mm/yy)

7) **Prognosis to resume regular duties:** ☐ **Good** ☐ **Poor** ☐ **Uncertain** ☐ **Permanent restrictions required, supported by objective medical**

8) **PHYSICAL and/OR COGNITIVE RESTRICTIONS MUST BE COMPLETED UNLESS DEEMED COMMUNICABLE AS PER SEC 1 If no restrictions are indicated, please provide a rationale to support total disability and absence from work.**

Current Physical Limitations:

☐ No Physical restrictions ☐ Graduated Hours
☐ Lifting up to _____kg
☐ Pushing/Pulling: ☐ Avoid ☐ No Repetitive ☐ Up to _____kg
☐ Over Shoulder work: ☐ Avoid ☐ No Repetitive ☐ Up to _____kg
☐ Standing/Walking _____minutes continuous
☐ Sitting_____ minutes continuous
☐ Bending/Twisting of_____
☐ Gripping/Pinching ☐ Avoid ☐ No Repetitive
☐ Other:_____

Current Psychological/ Cognitive Limitations:

☐ No Psychological/ Cognitive restrictions ☐ Graduated Hours

Frequency	Rare (< 5%)	Occasional (6–33%)	Frequent (34-66%)	Constant (> 67%)
Concentration	☐	☐	☐	☐
Communication	☐	☐	☐	☐
Critical Thinking	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Work Independently	☐	☐	☐	☐

☐ Medication side effects: _____
☐ Other: _____

Comments:

Please **fax this form to 905-743-5943** or email to **OccHealthACMS@lh.ca**

I the Treating Healthcare Professional attest that my patient is not using sick leave for any reasons: childcare concerns, bereavement leave, sick family members, education leave, elective/cosmetic tests/procedures or bad weather/transportation issues.

Practitioner's Name: _____

Professional Designation/Specialty (i.e. MD, Chiro, Physio, etc): _____

Phone: _____ Fax: _____

Signature: _____ Date: _____