Ontario Shores
Centre for Mental Health Sciences

Occupational Health & Wellness
700 Gordon Street, Whitby, Ontario, L1N 5S9
(905) 430-4055 Ext 6167, Confidential Fax (905) 665-2451

ATTENDING PRACTITIONER REPORT

The Ontario Medical Association (OMA) outlines in its **"Position in Support of Timely Return to Work (RTW) Programs and the role of Physicians**" that physicians should provide objective reports on impairment, medical restrictions and other supporting advice to the employee. In exchange for this information, the employers will offer the particular employee a plan for returning to suitable work in a timely fashion.

EMPLOYEE INFORMATION:

NAME:	**UNIT/DEPT:**	
Manager/Supervisor Name:	**JOB TITLE:**	
HOME ADDRESS:		**FIRST DAY ABSENT:**
PHONE # (Res):	**POSTAL CODE:**	

EMPLOYEE CONSENT

This consent shall remain valid until I return to full hours and duties at work related to the current short term absence from work on a sustained basis at Ontario Shores; or unless revoked orally, or in writing by me. When consent is revoked orally, it should be confirmed in writing within 48 hours.

I hereby authorize my physician/practitioner to disclose to Occupational Health and Wellness (OHW) information regarding my current injury/illness as it relates to my current absence from work, by completing this Attending Physician Statement, for the purposes of validating and managing my claim for a medical leave of absence, as it relates to my current injury/illness.

I authorize the Occupational Health Nurse to contact my physician/practitioner to clarify submitted information on this form only. This consent is granted on the understanding and condition that I will be advised in advance by OHW each time that it will be contacting my health care provider(s) in relation to this current absence from work **and why such contact is being made.**

I understand that the information will be disclosed to OHW for the purposes of eligibility for benefits, and/or supporting my needs for accommodation, and purposes related to or incidental thereto. I understand that the medical information will be kept in my confidential OHW file and that medical information will not be disclosed to a third party without my consent, except where otherwise required or permitted by law.

I understand that, for the purpose of eligibility for benefits, facilitating my return to work, information related to my restrictions and my accommodation requirements will be shared with my manager, supervisor, and/or with a Human Resources Consultant of Ontario Shores Centre for Mental Health Sciences.

Signature of Employee:____ **Date:**____________________

ILLNESS/INJURY/ACCOMMODATION INFORMATION (to be completed by treating practitioner):

Nature of Illness:	**Date injury/illness first began for current absence from work:**
Nature of illness/injury is a general statement of a person's illness/injury in plain language. Do Not Include ***technical medical details or diagnosis***	
Date first assessed for current absence from work:	**Date last assessed for current absence from work:**
Did this injury arise out of employment at Ontario Shores? ☐ YES ☐ NO WSIB #:	
Is this a recurring condition? ☐ YES ☐ NO	
Has a treatment plan been prescribed to the patient? ☐ YES ☐ NO	
If yes, is the patient compliant with the treatment plan? ☐ YES ☐ NO	
	Reassessment Date:

Note: 1) The Attending Practitioner Report is part of the Employee Health File and is subject to the requirements of applicable Personal Health Information and Medical Confidentiality requirements.
2) Physician's will receive reimbursement for completion of this form to a maximum of $42.50 when requested. The employee will be reimbursed once they submit paid receipt to Ontario Shores.

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EMPLOYEE NAME:

It is my professional opinion that this individual is currently (***please select ONE***):

☐ **Fit to return to FULL duties:** **RTW Date:** ______________________

☐ **Fit to return to Transitional duties:** **RTW Date:** ______________________

(Please indicate restrictions/accommodations in table below. Employees on transitional duties will be medically monitored).

FUNCTIONAL ABILITIES – If applicable to the current absence from work, please complete below

WALKING	☐ unable	☐ < 15 min	☐ 15 – 30 min	☐ 30 – 60 min
STANDING	☐ < 15 min	☐ 15 – 30 min	☐ 30 – 60 min	☐ > 60 min
SITTING	☐ < 15 min	☐ 15 – 30 min	☐ 30 – 60 min	☐ > 60 min
LIFTING (floor – waist)	☐ unable	☐ < 7 kg/15 lb	☐ < 14 kg/30 lb	☐ <25 kg/55 lb
	☐ minimal (<10%)	☐ occasional (11 – 34%)	☐ frequent (35 – 66%)	
LIFTING (overhead)	☐ unable	☐ < 2.3 kg/ 5 lb	☐ <7 kg/15 lb	☐ < 14 kg/30 lb
	☐ minimal (<10%)	☐ occasional (11 – 34%)	☐ frequent (35 – 66%)	
PUSHING/PULLING	☐ unable	☐ < 7 kg/15 lb	☐ < 14 kg/30 lb	☐ <25 kg/55 lb
	☐ minimal (<10%)	☐ occasional (11 – 34%)	☐ frequent (35 – 66%)	
CLIMBING STAIRS/LADDER	☐ minimal (<10%)	☐ occasional (11 – 34%)	☐ frequent (35 – 66%)	
GRIPPING	☐ minimal (<10%)	☐ occasional (11 – 34%)	☐ frequent (35 – 66%)	
REACHING ABOVE/BELOW SHOULDER (*please specify*)	☐ minimal (<10%)	☐ occasional (11 – 34%)	☐ frequent (35 – 66%)	
BENDING/TWISTING/CROUCHING/KNEELING (*please specify*)	☐ minimal (<10%)	☐ occasional (11 – 34%)	☐ frequent (35 – 66%)	
SHIFT RESTRICTIONS (i.e. Reduced Hours, Shift Issues, Personal Protective Equipment required, etc.).				

COGNITIVE ABILITIES - If applicable to the current absence from work, please complete below

Coherent	☐ YES	☐ NO	
Judgment	☐ GOOD	☐ ADEQUATE	☐ POOR
Concentration	☐ GOOD	☐ ADEQUATE	☐ POOR
Can this person work	☐ Independently?	☐ With supervision?	☐ With assistance?

Transitional duties will apply for approximately:
☐ **1 – 2 days** ☐ **3 -7 days** ☐ **8 – 14 days** ☐ **14 + days** ☐ **Other(please specify):** ______________________

Practitioner Signature:	**Date:**	**Office Stamp:**
Practitioner Name:		
Address:		
City:	**Postal Code:**	
Telephone:	**Fax:**	

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