Hamilton Health Sciences
HEALTH, SAFETY AND WELLNESS

ASMP Exclusion Form

Employee Information:		
Last Name:	First Name:	Employee ID #:
Street Address:	City:	Postal Code:
Home Phone Number:	Job Description/Title:	Department:

Dear Doctor:

Hamilton Health Sciences (HHS) has an Attendance Support and Management Program. Entry into the program is based on an employee missing 150 hours of work and / or having six (6) or more occurrences in the past calendar year. There are certain medical conditions that can be excluded from the program. Your patient has indicated that their sick-related absences may qualify as an exclusion. **In order to assess whether an exclusion applies, we require further information as outlined on the following page.**

Send completed form marked "confidential" **and your invoice** to:

Health, Safety and Wellness
Hamilton Health Sciences – King West
P.O. Box 2000, Hamilton, ON L8N 3Z5
OR: Fax: 905-577-8379 Email:
ability@hhsc.ca

Section A - Consent Information (To be completed by employee)

I authorize my treating, medically qualified health care professional _____
(Name)
to provide Health, Safety and Wellness with information **relative to my illnesses and inability to work** by completing Section B. I understand that **this is a voluntary employee process to apply for an exclusion** and that the Hospital will use this information to determine eligibility for exclusion from the Attendance Management and Support Program. I accept a photocopy or other reproduction of this authorization is as valid as the original.

Employee's Signature: _____ Date: ___/___/___
DD MM YY

Section B

In order to consider the employee request, please check (√) the type of absence, should it meet one of the following Attendance Support and Management Program exclusion criteria:

□ **One of the following Communicable Diseases (only these):**

- Probable Enteric Bacterial Infection causing diarrhea and / or vomiting
- Group A Streptococcal Infections including streptococcal pharyngitis, impetigo or pyoderma
- Acute Primary Oropharyngeal Herpes Simplex and Herpetic Whitlow NOT Oral and orofacial herpes simplex infections
- Suspected or diagnosed influenza ONLY from October to May
- Meningococcal disease including meningococcemia, meningococcal meningitis, or meningococcal pneumonia
- Measles, Mumps, or Rubella
- Pertussis (whooping cough) treated with antimicrobial treatment
- Scabies
- Acute chickenpox or disseminated zoster

Date(s) of Total Disability: _____

□ **An ongoing course of treatment that renders an individual incapacitated during or following the treatment**

Date(s) of Total Disability: _____

□ **A Catastrophic Event directly responsible for causing a marked impairment or an extreme impairment affecting Activities of Daily Living, Social functioning, Concentration and Adaptation and was under doctor's care during the dates of absence**

Date(s) of Total Disability: _____

□ **Medically necessary surgical interventions**

Date(s) of Total Disability: _____

Section C

Notice to physician and/or other qualified medical health care professional: Any information provided by you to Hamilton Health Sciences may be disclosed to the patient and/or those authorized by him/her to receive such disclosure.

Physician's Signature: _____ Date: ___/___/___
DD MM YY

Print name: _____ Phone number: ( ) _____