MEDICAL CERTIFICATE OF DISABILITY

For use by all Part-Time Non-Union, PIPSC, OPSEU, CUPE and ONA represented employees not in receipt of paid benefits.

Send completed form marked "confidential" 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

The information on this form is being collected by Hamilton Health Sciences' Health and Ability Services for the purpose of adjudicating and making a recommendation concerning the employee's absence and return to work.

Section A General Information

Employee Name: _____ Job title: _____

Address:_____
City Province Postal Code

Date of Birth:___/___/___ Date of employment: ___/___/___ Last Day Worked: ___/___/___
DD MM YY DD MM YY DD MM YY

Employee's Home Phone #: ( ) _____ Work Phone #: ( ) _____

Section B Consent Information (To be completed by employee)

I authorize my treating, medically qualified health care professional _____ to provide
(Name)
Health and Ability Services with information **relative to my claim** by completing Section C. Medical information will be kept confidential by Health and Ability Services and not disclosed further unless required by law. I understand that my manager will be notified concerning my fitness for work (A statement indicating whether I am unfit for work, fit to work with certain restrictions, or fit for regular work) and will be provided with information regarding my restrictions relevant to my RTW and accommodation. I accept a photocopy or other reproduction of this authorization is as valid as the original.
Employee's Signature: _____ Date: ___/___/___
DD MM YY

Section C – Disability Information (To be completed by Employee's Physician or other Qualified Medical Health Care Professional)

In order to support the medical absence of this employee and to facilitate his/her return to work we require specific information. Hamilton Health Sciences is committed to providing a transitional-modified work program for its personnel and requires your guidance to ensure a timely and safe return to work. **This certificate will be deemed incomplete unless all information requested under Section C is complete.**

1. Please identify if the employee is unable to work as a result of illness or injury. ___ Yes or ___ No (without diagnosis or symptoms).

_____

_____

2. History

Symptoms began or accident happened on: ___/___/__ First visit: ___/___/___
DD MM YY DD MM YY

Illness or injury forced cessation of work on: ___/___/__ Is this a work-related illness-injury? ____Yes ____No
DD MM YY

3. Current findings

Did you undertake an objective medical assessment that supports the illness/injury? ____Yes ____No

On what date did you make this medical assessment? ___/___/__
DD MM YY

_____

_____

4. Prognosis

Estimated date of return to full duties on a full time basis. ___/___/___
DD MM YY

With modifications to the employee's work or environment would the employee be able to return to work at an earlier date? ____Yes ____No

If "Yes", please estimate date of return to modified work :_____

The employer has a well-established comprehensive modified work program. Please outline your patient's functional capacity and restrictions so that an appropriate return to work plan can be developed.

_____

_____

_____

Please provide any other pertinent details about the return to work plan.

_____

_____

_____

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

If requested by Hamilton Health Science, they will pay the fee for completion of this form upon presentation of an original receipt. Receipts may be mailed to: Health, Safety and Wellness, Hamilton Health Sciences – King West, P.O. Box 2000, Hamilton, ON L8N 3Z5

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

Print name: _____ Phone number ( ) _____