Hamilton Health Sciences
HEALTH, SAFETY AND WELLNESS

# OPSEU Local 273 - 6th & Subsequent Exemption Form

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

Dear Doctor:

We require further information, as outlined below, in order to ensure that employees who have chronic medical conditions that may require periodic, short absences are not subject to the "6th & Subsequent Absence penalty" as per Article 15.01(c) of the OPSEU Local 273 Collective Agreement.

**Note, a medically established serious chronic condition** – is defined as a disease:

- Of long duration; and
- Generally slow progression; and
- Having a dangerous possible result; and
- Having had a specialist involved in consultation and / or management.

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 chronic illness(es) and inability to work** by completing Section B. I understand that **<u>this is a voluntary employee process to apply for an exemption</u>** and that the Hospital will use this information to determine eligibility for exemption from OPSEU's 6th & Subsequent penalty as per Article 15.01(c). 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

### TREATING PRACTITIONER RESPONSE

1. Does your patient have a **medically established serious chronic condition based on the above definition**?
   ☐ Yes ☐ No Nature of condition: ____________________________________________
2. Has the employee been seen by a specialist? ☐ Yes ☐ No

3. Please confirm the employee was unable to attend work related to this diagnosis on the following date(s):
_______________________________________________________________________________________________

**Section C**

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**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: (      ) __________________