Hamilton Health Sciences

MEDICAL CERTIFICATE OF DISABILITY

For use by all OPSEU 273 represented employees only

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 Ability Services for the purpose of adjudicating and making a recommendation to Hamilton Health Sciences ("Hospital") concerning eligibility for Short Term Disability benefits under the 1992 HOODIP.

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)
Ability Services with information **relative to my claim** by completing Section C. Medical information will be kept confidential by Ability Services and not disclosed to any other individual unless required by law. I understand that the Hospital will be notified concerning my eligibility for benefits and will be provided with information relevant to my return to work 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 the general nature of the illness or injury (without diagnosis or symptoms).

_____

_____

2. History

Symptoms began or accident happened on: ___/___/___ (DD MM YY)

First visit: ___/___/___ (DD MM YY)

Illness or injury forced cessation of work on: ___/___/___ (DD MM YY)

Is this a work-related illness-injury? ____Yes ____No
If yes, please submit a Form 8 to WSIB.

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

Is further assessment required? ___ Yes ____ No

If yes, Date of Next visit: ___/___/___ DD MM YY

Is your patient capable of performing the regular duties of the occupation in which he/she participated immediately before becoming disabled? ____ Yes ____ No

If "No", please comment:

_____

_____

4. Treatment

Is the employee under active, continuous and medically appropriate care for his/her disability? ____Yes ____No

5. 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 Ability Services may be disclosed to the patient and/or those authorized by him/her to receive such disclosure.

Hamilton Health Sciences 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 ( ) _____