APPLICATION FOR DISABILITY BENEFITS/LEAVE

When information is requested to support an employee's medical absence from work, this Application for Disability Benefits/Leave form must be completed. Personal medical information is kept in your confidential employee health record in the Occupational Health and Safety Department (OHS). Personal medical information is not shared with your Department Head or anyone else without your written consent. OHS will notify you if there is not enough information to support your medical absence from work and you will be asked to submit the required information. When supporting information is required, please note that you will not be paid sick time until the appropriate medical information is received.

REMINDER: You must report your absence from work daily to your department following your department procedures.

Part A – Employee Identification (Employee to complete)

<table>
<tr><td colspan="3">Full Name</td><td colspan="2">Date of Birth</td></tr>
<tr><td colspan="3">Home Address

City Postal Code</td><td colspan="2">Primary Telephone #</td></tr>
<tr><td>Position

Status: FT PT CAS</td><td>Department</td><td colspan="2">Manager</td><td>Site
[ ] Markham
[ ] Uxbridge</td></tr>
<tr><td colspan="2">1st shift absent from work (date & hours)</td><td colspan="3">Date seen by healthcare practitioner</td></tr>
</table>

Part B – Employee Consent (Employee to complete)

I agree to the following:

- The statements on this form are true and complete to the best of my knowledge
- I hereby authorize my healthcare practitioner to release the information on this form to the Markham Stouffville Hospital Corporation's Occupational Health and Safety Department (OHS)
- A photocopy or faxed version of this authorization is as valid as the original and shall continue to have effect throughout the duration of my absence.
- Only information regarding my work-related limitations or restrictions will be reported to my Manager (or designate), for the purposes of planning and managing my accommodation at work.
- OHS will keep all the information provided in my confidential employee health record.
- I hereby authorize my healthcare practitioner to provide information in relations to the medical condition which gave rise to my current disability and for which I am applying for benefits, to OHS at Markham Stouffville Hospital in determine my fitness to work.
- I can revoke my consent at any time. Revoke of consent must be done in writing.

Employee Signature	Date

Part C – Healthcare Practitioner Statement (Completed by Healthcare Practitioner)

Please provide the following information to support this employee's medical absence from work at Markham Stouffville Hospital Corporation. Any question or concerns, please call the Hospital's Occupational Health Department at the appropriate number below.

<table>
<tr><td>Nature of injury/illness (Diagnosis not required)</td><td>Date of Onset:</td></tr>
<tr><td colspan="2">Communicable Disease* ☐ YES. Type of illness: ______________________________ ; ☐ NO
*As per Public Health Reportable Communicable disease lists.</td></tr>
<tr><td>Date first assessed;</td><td>Date last assessed:</td></tr>
<tr><td colspan="2">Date of next visit:</td></tr>
<tr><td colspan="2">Did this injury/illness arise of employment at the hospital? ☐ YES ☐ NO WSIB #:</td></tr>
<tr><td colspan="2">Is this a recurring condition? ☐ YES ☐ NO</td></tr>
<tr><td colspan="2">Prognosis of condition:</td></tr>
<tr><td>Has a referral been made to a specialist?
☐ YES ☐ NO</td><td>Anticipated date of specialist appointment</td></tr>
<tr><td colspan="2">Employee is under active treatment plan?
☐ YES ☐ NO</td></tr>
</table>

Specified period of absence (total disability):

This statement confirms the above named has been under my care for the illness identified on this form and supports a medical absence from _____/_______/______ to _____/______/______
(dd / mm / yy) (dd / mm / yy)

Part D: Please indicate which of the following Work Placement is suitable for this employee

The hospital is committed to establishing a proactive strategy to assist employees in returning to work after a workplace related or non-workplace related illness/injury. We are committed to providing modified duties/hours to support the recovery period. The documentation below will assist the hospital in developing the appropriate early and safe return to work plan for your patient.

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

☐ **Fit to return to FULL duties on**: (Date)_______________________________________

☐ **Fit to return to MODIFIED duties on**: (Date)___________________ Duration:___________________
Please indicate the level of modified duties in the relevant section(s) below and specify duration of limitations:

☐**Sedentary** Duties: Sitting; No requirement to lift, carry, push/pull or climb
☐**Light** Duties: Standing and/or sitting; Limited carrying no greater than 5 kg; Walking from one task to another; Limited lifting, pushing/pulling, no greater than 10 kg: No climbing
☐**Medium** Duties: Standing, walking, sitting as required; Limited lifting, carrying, pushing or pulling no greater than 15 kg; Limited climbing
List of restrictions not indicated above____
____

Please complete <u>only</u> if the current disability is of a Cognitive nature,

[ ] if symptoms are present, they are transient and expected reactions to psychosocial stressors no more than slight impairment in occupational functioning [ ] some mild symptoms OR some difficulty in occupational functioning but generally functioning pretty well [ ] moderate symptoms OR moderate difficulty in one of the following occupational functioning. [ ] my patient's occupational functional abilities are above the above listed classifications. [ ] my patient's occupational functional abilities are below the above listed classifications	Coherent __ Yes __ No Judgment ___ Good ___Adequate ___Poor Concentration___ Good ___Adequate ___Poor Able to Follow and Provide Instructions: Yes___ No___ Can this person work : _ Independently? _ With supervision? _ With assistance? Describe Patient's Current Symptoms including Functional Limitations: ____ ____ ____

☐ **UNFIT work (**i.e., **TOTALLY DISABLED**, meaning hospitalized or otherwise incapable of performing acts of daily living***: Expected duration of TOTAL disability: _____________ Next assessment date: ___________

*****Please state reasons why this employee cannot return to modified duties, as per the Canadian Medical Association's GUIDELINES FOR RETURN TO WORK AFTER ILLNESS OR INJURY and as per legislative requirements for accommodation:**____

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

Form to be submitted to the Occupational Health and Safety Department at Markham Stouffville Hospital

Markham Site: 905-472-7373 ext. 6280; Uxbridge Site 905-852-9771 ext. 5233
Fax # 905-472-7626