Occupational Health, Safety & Wellness

Attending Practitioner Report

Employee Information and Consent (to be completed in full by employee ONLY)

Name (last, first): _____

Contact Number: _____ Status: ☐ Full-time ☐ Part-time ☐ Temporary

Manager: _____ Department: _____

Occupation: _____ First Day Absent (DD/MM/YYYY): _____

I hereby authorize the practitioner, by completing and signing this form, to fill out and release all sections of this form to my employer's Occupational Health, Safety & Wellness Department (OHSW) for the purposes of validating and managing my medical leave of absence, as it relates to my fitness for work. I understand that OHSW will keep my medical information confidential and it will be used to facilitate my return to work. I consent to allow OHSW to release the status of my absence, the duration, and my ability to return to work (including any restrictions) to only those individuals necessary to facilitate my medical leave, return to work, and/or accommodation.

By signing below, I acknowledge my understanding of the information above and I agree to provide my consent accordingly.

Employee signature: _____ Date (DD/MM/YYYY): _____

Practitioner's Report (to be completed in full by MD, NP or Physiotherapist Only)

Please complete this form to assist us in determining your patient's eligibility for sick leave due to total disability. Please note that if your patient is not able to perform the regular duties of their job, we may be able to provide suitable modified work. Please complete all applicable sections and return this form promptly to ensure continuation of wages and/or benefits for your patient.

If this is a workplace injury or illness, STOP! Do not use this form. Complete a WSIB Form 8.

1. Nature of illness/injury (no diagnosis required), e.g. neurological, orthopedic, respiratory, mental health:

_____

☐ Communicable disease potentially reportable to Public Health
☐ Hospitalized or fully bedridden from to
☐ Surgical Matter: OHIP Covered ☐ YES ☐ NO
☐ Recurrent condition

2. First date of injury/illness (DD/MM/YYYY): _____

   Date of first visit for current health issue (DD/MM/YYYY): _____

3. Is the patient participating in an active treatment plan? ☐ YES ☐ NO

4. If the patient is participating in an active treatment plan (e.g. medication/physiotherapy/counseling, etc.) please provide details. **Please note: if your patient is a Registered Nurse, hired by PRHC prior to January 1, 2006, you do not need to complete question.**

_____

_____

5. Is the patient presently under the care of a physician/other specialist?
   ☐ YES ☐ NO If no, has a referral occured? ☐ YES ☐ NO ☐ N/A

6. Unable to perform job duties as of this date (DD/MM/YYYY): _____

   Expected return to regular duties (DD/MM/YYYY): _____

_____

Functional Abilities (to be completed by qualified MD, NP, or Physiotherapist)

Was a formal assessment, testing, or measurement done to determine functional abilities? ☐ YES ☐ NO

Physical limitations: ☐ N/A

Physical Abilities

Lifting floor to waist	☐ 5-10kg	☐ Up to 5kg	☐ Other:
Lifting waist to shoulder	☐ 5-10kg	☐ Up to 5kg	☐ Other:
Lifting at or above shoulder	☐ 5-10kg	☐ Up to 5kg	☐ Other:
Reaching	☐ No over shoulder	☐ No overhead	☐ Other:
Sitting/standing/walking	☐ Up to 60 min.	☐ Up to 30 min.	☐ Other:
Pushing/pulling	☐ Occasional		☐ Other:
Bending/crouching/kneeling/climbing	☐ Occasional		☐ Other:
Hand function	☐ Avoid gripping/pinching		☐ Other:

Cognitive limitations: ☐ N/A

Cognitive Abilities

☐ Concentration ☐ Attention ☐ Memory ☐ Communication

☐ Ability to use motorized vehicle, machinery and/or equipment

☐ Judgment (explain): _____

☐ Medication side effects: _____

☐ Other: _____

Comments: _____

_____

_____

Practitioner's Full Name: _____

Professional Designation/Specialty: _____

Signature: _____

(DD/MM/YYYY): _____

Practitioner's Stamp

Employees are responsible for the cost of the form being completed at the time of service and must submit the invoice to OHSW within one month of the service for reimbursement. A maximum of $40 will be paid to the employee. Please provide the employee with a receipt if they have paid the fee.