

ATTENDING PRACTITIONERS STATEMENT - FORM B - Only for ONA EMPLOYEES

Hired before January 1, 2006

Section A - Employee Information: *(to be completed by employee)*

Name: _____ Job Title: _____
 Address: _____ City: _____ Postal Code: _____
 Phone: _____ Manager/Supervisor: _____ Phone: _____
LAST DAY WORKED: _____ **FIRST MISSED SHIFT:** _____

Section B - Consent: *(to be completed by employee)*

I consent to allow OH&S to provide information related to my fitness for work and any accommodation needs to my manager/supervisor and Union Representative (if applicable)

 Signature Date

Section C: *(to be completed by qualified medical health practitioner)*

Dear Practitioner: Please be advised that by completing this form you are certifying that the information is true and accurate and is in keeping with professional standards outlined by the professional and regulatory bodies that govern your practice. You further understand that all information requested must be fully completed to ensure the employer can determine the employee's eligibility for salary replacement benefits.

Date first incapable of working: _____

Date first assessed to be totally disabled from all duties of: _____

Dates subsequently examined: _____

Specified period of absence: _____ (total disability)

Nature of illness or injury: _____ (no diagnosis)

Employee is under active treatment: _____

Prognosis/Return to work date: _____

Complete recovery expected: _____

Section D

Dear Practitioner: UHN/TRI supports early and safe return to work. We are committed to providing modified duties to support the recovery process. Please fully complete the appropriate boxes below.

Nature of illness - Please tick all that apply

A communicable disease potentially reportable to Public Health

A surgical matter OHIP COVERED: Yes No

Workplace Injury/Illness (WSIB)

☐ **Fit to return to full duties:**

Date:

☐ **Employee unfit to work** - Please articulate and describe any / all physical and cognitive impairments that are preventing this employee from performing **any and all work**:

Duration:

Reassessment Date:

☐ **Employee fit for Modified Work** - Please indicate specific functional limitations:

Duration:

Reassessment Date:

By affixing my signature below, I certify that I am a qualified medical practitioner and that I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.

PRACTITIONER'S NAME: (Please Print) _____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

SIGNATURE:

DATE:

Once completed please return by fax to the number indicated below:

FULLY COMPLETE THE FUNCTIONAL
ABILITIES FORM ATTACHED (IF APPLICABLE)

☐ **TGH**

Tel: 416-340-3267

Fax: 416-340-3463

Email: OHSTGH@UHN.CA

☐ **PMH**

Tel: 416-946-2090

Fax: 416-946-2093

Email: OHSPMH@UHN.CA

☐ **TWH**

Tel: 416-603-5121

Fax: 416-603-5101

Email: OHSTWH@UHN.CA

☐ **TRI**

Tel: 416-597-3422 x3068

Fax: 416-597-3026

Email: OHSTRI@UHN.CA

Functional Abilities Form

For Early and Safe Return to Work



Please PRINT clearly

Employee's Last Name	Employee's First Name
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The following information should be completed by the treating Practitioner to identify the patient's overall abilities and restrictions.

Date of Assessment		
DD	MM	YYYY

Abilities and/or Restrictions

1. Please indicate Abilities that apply, include additional details in section 3.				
Walking		Standing		Sitting
Full abilities	Full abilities	Full abilities	Full abilities	Full abilities
Up to 100 metres	Up to 15 minutes	Up to 30 minutes	Up to 5 kilograms	
100 – 200 metres	15 – 30 minutes	30 minutes – 1 hour	5 – 10 kilograms	
Lifting from waist to shoulder				
Full abilities	Full abilities	Full abilities		
Up to 5 kilograms	Up to 5 steps	1 – 3 steps		
5 – 10 kilograms	5 – 10 steps	4 – 6 steps		

2. Please indicate Restrictions that apply, include additional details in section 3.							
Check all that apply and fill in specifics							
Bending/twisting repetitive movement of (please specify)	Work at or above shoulder activity:	Environmental exposure to (e.g. heat, cold, noise or scents)	Left	Limited use of hand (s):	Right		
				Gripping			
				Pinching			
				Other (please specify)			
Limited pushing/pulling with: Circle One	Left Arm	Operating motorized equipment (e.g. forklift)	Potential side effects from medications (please specify. Do not include names of medications)	Exposure to vibration Circle One	Whole body		
	Right Arm				Hand		
	Other:				Arm		

3. Additional Comments on Abilities and/or Restrictions:				
4. From the date of this assessment, the above will apply for approximately:				
1 – 2 days	3 – 7 days	8 – 14 days	14 + days	

Date of Next Assessment:			DD	MM	YYYY
Treating Practitioner's Name & Title:	Address:	Signature:			
Telephone:		Date:			
Fax:					

All requests for reimbursement of APS forms must be made **within 3 months from the date of service.**