OCCUPATIONAL/NON-OCCUPATIONAL INJUY OR ILLNESS
EMPLOYEE HEALTH SERVICES

EMPLOYEE AUTHORIZATION: I authorize Dr. ____________________ to give documentation of my current medical condition to the CONFIDENTIAL ATTENTION of the Employee Health Department at Timmins and District Hospital.
We will use the personal information we receive from your personal physician to assess the validity of your absence from work and your entitlement to sick pay (or short term disability benefits); and ensure your safe return to work and develop an accommodation plan.

Proof of Total Disability (such as a doctor's certificate), that is satisfactory to your employer, is required if you are absent for three days or more, and is subject to a periodic review thereafter.

____________________ ____________________ ____________________ Status ☐ FT ☐ PT ☐CAS.

Employee Name Employee Signature Date

HEALTH CARE PRACTITIONER'S STATEMENT

1. **Date of Assessment** ____

2. **Nature of Illness** ____
____

3. **Complicating Factors**____

4. **Is the employee following the recommended treatment plan?** ☐ **Yes** ☐ **No, if No explain** ________________________

5. ☐ **Non-occupational Illness or Injury** ☐ **Occupational Illness or Injury**

6. **Totally disabled from:** ________________________ **to** ________________________

7. **Able to return to work:** ☐ **Yes (Complete 8)** ☐ **No If No then estimated date of return to work:** ____________________

8. **Able to return to work without restrictions:** ☐ **Yes Return to Work Date:** ____________________ ☐ **No (If no, complete 9)**

9. **Partially Disabled –Restrictions to Normal Duties. TDH has a modified work program and endeavors to accommodate the restrictions of our injured/ill employees to provide a safe and timely return to work.**
FUNCTIONAL LIMITATIONS IMPOSED BY MEDICAL ILLNESS/INJURY:

Lifting ___________**lbs/kgs** **Bending** ________________ **Standing** ______________**hrs/shift**

Sitting ___________ **hrs/shift** **Reaching** ________________ **Pushing/pulling**________________

Other____

Hours of Work______________________________

Probable duration of limitations: ____

10. **Would a call from a Nurse or Physician be helpful?** ☐ **YES** ☐**NO**

11. **Comments:**____
____

______________________________ ______________________________ ______________________________

Practitioner's Signature **Practitioner's Name (Printed)** **Date**

____

Office Stamp / Address(Please Include)

Timmins and District Hospital will pay $25. for providing appropriate medical documentation.

PLEASE RETURN TO THE EMPLOYEE HEALTH DEPARTMENT

CONFIDENTIAL FAX: 705-267-6335