

ATTENDING PRACTITIONER STATEMENT - FORM A

For All UHN Employees, and ONA Employees hired after January 1, 2006

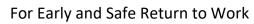
Name:	Job Tit	itle:
Address:	City:	Postal Code:
Phone:	Manager/Supervisor:	Phone:
LAST DAY WORKED:	FIRST M	NISSED SHIFT:
Section B - Consent: (to be		
	provide information related to my and Union Representative (if application)	fitness for work and any accommodation needs cable)
Signature		Date
Section C - (to be complet	ed by qualified medical practitioner	r)
Date first incapable of work	ing:	e's eligibility for salary replacement benefits.
Specified period of		(total disability)
Nature of illness or injury:		(no diagnosis)
Employee is under your acti	ve, continuous and medically appro	opriate care:
Please describe treatment p	provided:	
Please describe treatment p	plan:	
Prognosis/Return to work d	ate:	
Complete recovery expected	d: Employee is	s compliant with treatment:

Revised November 2017 PLEASE TURN OVER >

Section D

		and safe return to wor ocess. Please <u>fully</u> com		
A communica A surgical mat	ter OHIP COVERED:	eportable to Public Health	or submission	
Fit to return to	full duties:			
		and describe any / all phy rming any and all work :	-	airments that
		·	·	
Duration:		Reassess	ment Date:	
□ Employee fit for	Modified Work - Please	indicate specific function	al limitations:	
Duration:		Reassessm	ent Date:	
the above patient/emplo	oyee. It is my opinion that	qualified medical practition the information is true and a	accurate.	ally assessed and treated
ADDRESS:				
TELEPHONE:		FAX:		
SIGNATURE:			DATE:	
Once completed please	return by <u>fax</u> to the numbe	er indicated below:		OMPLETE THE FUNCTIONAL ABILITIES (TACHED (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	☐ WP Tel: 416-243-3600 Fax: 416-243-3752 Email: OHSWestpark@uhn.ca

Functional Abilities Form





Please PRINT clearly										
Employee's Last Name		Employee's First Name								
The following information s	hould b	e completed	by t	he tre	eating Practit	tioner	to ide	ntify the	e patient'	S
overall abilities and restricti	ons.	·	•					•	•	
Date of Assessment										
DD MM YYYY										
Abilities and/or Restrictions										
1. Please indicate Abiliti Walking	es that a		Iditio	tional details in section 3.				Lifting from floor to waist		
Full abilities	Ful	Standing abilities			Sitting Full abilities				abilities	
Up to 100 metres		to 15 minutes			Up to 30 minu	ıtoc		Up to 5 kilograms		
100 – 200 metres		– 30 minutes			30 minutes –			10 kilograms		
100 – 200 metres	15	- 30 minutes			30 minutes –	1 nour		3-10	Kilograffis	
Lifting from waist to shoulder	:	Stair climbing			Ladder climbi	ng:				
Full abilities	Ful	l abilities			Full abilities					
Up to 5 kilograms		to 5 steps			1 – 3 steps					
5 – 10 kilograms	5 –	10 steps			4 – 6 steps					
2. Plane to the to Breat				!!!! I	d - a - 11 - 1 a 1	2				
 Please indicate Restrict Check all that apply an 			e add	iitionai	details in section	on 3.				
Bending/twisting		k at or above		Enviro	nmental	Left	Limit	ed use of	hand (s):	Rght
repetitive movement of	shou	ılder activity:	exposure to (e.g.		ure to (e.g.		Gripping		ng	
(please specify)					eat, cold, noise or					
				scents)		Pinching		ng		
							Oth	er (please	specify)	
]]							
				Poten	tial side					
Limited Left Arm		erating effects fr							body	
pushing/pulling		otorized uipment (e.g. klift)		medications (please specify. Do not include names of medications)		Exposure to vibration Circle One			\Box	
with: Right Arm	-							on	Han	d
Circle One Other:	IOTA							ne		\Box
					•				Arm	1
3. Additional Comments	on Abili t	ties and/or Rest	rictio	ons:						
4. From the date of this			vill a	pply to		y:		144.	dava	
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:						
-1.1				Bata						
Telephone: Fax:						Date:				