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

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: _____

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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)** **If WSIB, please complete FORM 8 for submission to Workplace Safety and Insurance Board.**

☐ **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

☐ **WP**
Tel: 416-243-3600
Fax: 416-243-3752
Email: OHSWestpark@uhn.ca

Functional Abilities Form

For Early and Safe Return to Work

Please PRINT clearly

Employee's Last Name	Employee's First Name

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**	**Lifting from floor to waist**
☐ 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	**Stair climbing**	**Ladder climbing:**
☐ 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):	Rght
						☐	Gripping	☐
						☐	Pinching	☐
						☐	Other (please specify)	☐

Limited pushing/pulling with: Circle One	☐ Left Arm ☐ Right Arm ☐ Other:	☐	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 ☐ Hand ☐ 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: Telephone: Fax:	Address:	Signature: Date:

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