



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: _____ Worksite: _____
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)

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)

UHN Health Services
Email: OHSsubmissions@uhn.ca
Phone: 416-979-4441
Fax: 416-340-3463

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	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			
Full abilities	Full abilities	Ladder climbing:	
Up to 5 kilograms	Up to 5 steps	Full abilities	
5 – 10 kilograms	5 – 10 steps	1 – 3 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:	Left Arm <input type="checkbox"/>	Right Arm <input type="checkbox"/>	Other: <input type="checkbox"/>	Operating motorized equipment (e.g. forklift)	Potential side effects from medications (please specify. Do not include names of medications)	Exposure to vibration	Whole body <input type="checkbox"/>
Circle One						Circle One	Hand <input type="checkbox"/>
							Arm <input type="checkbox"/>

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
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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.**