UNIVERSITY of GUELPH
HUMAN RESOURCES
OCCUPATIONAL HEALTH AND WELLNESS

Attending Physician's Form
Occupational Health & Wellness
E-Mail: ohw@uoguelph.ca
Phone: 519-824-4120 ext. 52647 Fax: 519-780-1796

The University of Guelph has a self-funded sick leave program which provides income continuance for verifiable illness and injury for eligible employees. The University is committed to making every reasonable effort to assist ill or injured employees in their return to work. Please provide the following information to assist us in planning for your patient's safe return to work.

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

NAME: (Surname)	**(Given Names)**	**Date of Birth (DD/MM/YYYY)**
HOME ADDRESS: (Street, City, Postal Code)		**HOME/CONTACT PHONE NO.**
FACULTY/SCHOOL/SERVICE	**DEPARTMENT**	**JOB TITLE**
MANAGER/SUPERVISOR NAME		**PHONE NO.**
LAST DAY WORKED:	**DATE OF FIRST MISSED SHIFT:**	

Section B: Medical Information (t*o be completed by a qualified medical practioner).*

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 short term disability/sick leave benefits.

General Nature of illness or injury: _____

Is the Employee under your direct, continuous and medically appropriate care? ☐ Yes ☐ No

Is the employee following a recommended treatment plan? ☐ Yes ☐ No

Estimated Return to Work Date: _____

Is complete recovery expected? ☐ Yes ☐ No

Do you believe this illness or injury is work related ☐ Yes ☐ No If yes, please complete a WSIB Form 8.

Please indicate your patient's ability to return to work:

☐ **Employee unfit to work** **From:** (DD/MM/YYYY) _____ **To:** (DD/MM/YYYY)_____

Please describe the impairment that is preventing this employee from performing any/all work:

Reassessment Date: (DD/MM/YYYY) _____

☐ **Employee fit to return to full duties** **Effective Date (DD/MM/YYYY): _____**

☐ **Employee fit to return to modified duties (See Functional Capacity information).**

Effective Date (DD/MM/YYYY): _____

☐ **Employee fit to return to modified hours- Specify:_____**

Duration: _____ **Reassessment Date: _____**

Name: _____ Department: _____

The University of Guelph supports early and safe return to work. We are committed to fulfilling our accommodation obligations, providing modified duties, where available and appropriate, to support the recovery process. Please fully complete the following boxes as appropriate to identify your patient's capabilities / limitations.

Capabilities:

Walking:	☐ full abilities	☐ Up to 100 mins	☐ 100-200m	☐ other _____
Standing:	☐ full abilities	☐ Up to 15 mins	☐ 15-30 mins	☐ other _____
Sitting:	☐ full abilities	☐ Up to 30 mins	☐ 30mins – 1 hr	☐ other _____
Lifting floor to waist:	☐ full abilities	☐ Up to 5 kgs	☐ 5 – 10 kgs	☐ other _____
Lifting waist to shoulder	☐ full abilities	☐ Up to 5 kgs	☐ 5 – 10kgs	☐ other _____
Stair climbing:	☐ full abilities	☐ Up to 5 steps	☐ 5 – 10 steps	☐ own pace ☐ as tolerated
Ladder climbing:	☐ full abilities	☐ 1 – 3 steps	☐ 4 – 6 steps	☐ own pace ☐ as tolerated

Hand use (R/L): ☐ gripping ☐ pinching ☐ fine motor ☐ other _____

Limitations: Please indicate restrictions that apply.

☐ Bending/twisting repetitive movement of (please specify)	☐ Work at or above shoulder activity:	☐ Chemical Exposure to:	☐ Environmental exposure to: (e.g. heat, cold, noise or scents)	☐ Kneeling or Squatting
☐ Limited pushing/pulling with: ☐ Left Arm ☐ Right Arm ☐ Other (please specify)	☐ Operating motorized equipment: (e.g. forklift)	☐ Potential side effects from medications (please specify) Do not include names of medications.	☐ Exposure to vibration: ☐ Whole body ☐ Hand/Arm	

☐ Other

_____

Cognitive Functional Limitations (if applicable): Please indicate the cognitive limitations and associated severity.

Degree of Impairment

	None	Mild	Moderate	Severe
Multi-tasking	☐	☐	☐	☐
Memory	☐	☐	☐	☐
Attend to deadline pressures	☐	☐	☐	☐
Critical decision making	☐	☐	☐	☐
Working with others	☐	☐	☐	☐
Dealing with confrontation	☐	☐	☐	☐
Dealing with emotional situations	☐	☐	☐	☐
Other_____	☐	☐	☐	☐

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.

PHYSICIAN'S NAME: (Please Print) _____TELEPHONE: _____

ADDRESS: _____FAX: _____

DISCIPLINE/CREDENTIALS:

_____

SIGNATURE: _____DATE (DD/MM/YYY): _____

Once competed please upload to our OHW Secure Drive or fax to Occupational Health and Wellness at (519) 780-1796.

****Any costs associated with providing the above information will be the responsibility of the employee.**