HEALTH CARE PRACTITIONER'S STATEMENT

OCCUPATIONAL/NON-OCCUPATIONAL INJURY OR ILLNESS
OCCUPATIONAL HEALTH SERVICES

EMPLOYEE AUTHORIZATION: I authorize Dr./NP _____ to provide documentation of my current medical condition to the confidential attention of Occupational Health Services at Timmins and District Hospital.

The information received from your Health Care Provider is used to assess the validity of your absence and entitlement to short term disability benefits (sick pay), if applicable; and to ensure your safe return to work and development of a modified work plan, if necessary.

Proof of Total Disability by means of a Health Care Practitioner's Statement is required for absences of three days or more, and is subject to a periodic review thereafter.

_____ _____ _____ Status: ☐ FT ☐ PT ☐ CAS

Employee Name | Employee Signature | Date

1. **Date of Assessment:** _____
2. **Nature of Illness:** _____
3. **Complicating Factors:** _____
4. **Totally disabled from current job** ☐ **or any job** ☐ **from dates:** _____ **to** _____**inclusive.**
5. **Return to work Date:** _____ **or Reassessed Date:** _____
6. ☐ **Non-occupational Illness or Injury or** ☐ **Occupational Illness or Injury, Form 8 sent** ☐
7. **Able to return to work without restrictions:** ☐ **Yes** ☐ **No See section 9 if restrictions are required**
8. **Is the employee following the recommended treatment plan?** ☐ **Yes** ☐ **No, if No explain** _____

TADH 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

9. **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: _____

Would a call from a Nurse or Physician be helpful? ☐ **Yes** ☐ **No**

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 OCCUPATIONAL HEALTH SERVICES

CONFIDENTIAL FAX: 705-267-6335