PART 1
The Board may request this medical confirmation in accordance with Article C6.1 h)

Part 2 of this form is to provide the Employer with information to assess whether the employee is able to perform the essential duties of their position and to understand restrictions and/or limitations to assess workplace accommodation if necessary.

Part 2 need only be completed for a return to work that requires an accommodation.

I, _____,

hereby authorize my Health Care Professional(s)

_____,

to disclose medical information to my employer,

_____,
In order to determine my ability to fulfill my duties as a

_____,

from a medical standpoint, and whether my medical situation is such that it can support my sustained return to work in the foreseeable future. To this end, I specifically authorize my Health Care Professional(s) to respond to those questions from my employer set out
in the medical certificate dated

dd mm yyyy

for my absence starting on the

dd mm yyyy

Signature Date

Employee ID:

Employee Address:

Telephone No:

Work Location:

Dear Health Care Professional,

please be advised that the Employer has an accommodation and return to work program. The parties acknowledge that the employer has an obligation to provide reasonable accommodation to the point of undue hardship, and that the employee has an obligation to cooperate with reasonable accommodation measures. Consistent with this understanding, and with the objective of returning employees to active employment as soon as possible, we would ask the medical professional to provide as full and detailed information as possible.

Please return the completed form to the attention of:

Minh Hoang, Disability Support Coordinator

Phone: 905-713-1211 ext. 11607
Confidential Fax: 905-713-1289

The following information should be completed by the Health Care Professional:

First Day of Absence:

General Nature of Illness* *(please do not include diagnosis)*:

Date of Assessment:
dd mm yyyy

No limitations and/or restrictions ☐

Return to work date: **dd mm yyyy**

For limitations and restrictions, please complete Part 2.

Health Care Professional, please complete the confirmation and attestation in Part 3

PART 2 – Physical and/or Cognitive Abilities

Health Care Professional to complete. Please outline your patient's abilities and/or restrictions based on your objective medical findings *(please complete all that is applicable):*

PHYSICAL (if applicable)

Walking:
☐ Full Abilities
☐ Up to 100 metres
☐ 100-200 metres
☐ Other *(specify)*:

Standing:
☐ Full Abilities
☐ Up to 15 min
☐ 15-30 min
☐ Other *(specify):*

Sitting:
☐ Full Abilities
☐ Up to 30 min
☐ 30 min - 1 hour
☐ Other *(specify)*:

Lifting from floor to waist:
☐ Full Abilities
☐ Up to 5 kilograms
☐ 5 - 10 kilograms
☐ Other *(specify):*

Lifting from Waist to Shoulder:
☐Full abilities
☐ Up to 5 kilograms
☐5 - 10 kilograms
☐Other *(specify):*

Stair Climbing:
☐Full abilities
☐Up to 5 steps
☐ 6-12 steps
☐ Other *(specify):*

☐ **Use of hand(s):**

Left Hand
☐Gripping
☐Pinching
☐ Other *(specify)*:

Right Hand
☐Gripping
☐Pinching
☐Other *(specify)*:

☐
Bending/twisting
repetitive movement of *(please specify)*:

☐
Work at or above shoulder activity:

☐
Chemical exposure to:

Travel to Work:

Ability to use public transit ☐Yes ☐No

Ability to drive car ☐Yes ☐No

COGNITIVE (if applicable)

Attention and Concentration: ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Following Directions:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Decision-Making/Supervision:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Multi-Tasking:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:
Ability to Organize: ☐ Full Abilities ☐ Limited Abilities ☐ Comments	**Memory:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Social Interaction:** ☐ Full Abilities ☐ Limited Abilities ☐Comments:	**Communication:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:

Please identify the assessment tool(s) used to determine the above abilities (Examples: Lifting tests, grip strength tests, Anxiety Inventories, Self-Reporting, etc.)

Additional comments on Limitations (not able to do) and/or Restrictions (should/must not do) for all medical conditions:

Health Care Professional: The following information should be completed by the Health Care Professional

From the date of this assessment, the above will apply for approximately: ☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15 +days ☐ Permanent	Have you discussed return to work with your patient? ☐ Yes ☐No
Recommendations for work hours and start date (if applicable): ☐ Regular full time hours ☐Modified hours ☐Graduated hours	Start Date: **dd mm yyyy**

Is the patient on an active treatment plan?: ☐ Yes ☐No

Has a referral to another Health Care Professional been made?

☐ Yes (optional- please specify)_____ ☐ No

If a referral has been made, will you continue to be the patient's primary Health Care Provider?

☐ Yes ☐No

Please check one:

☐ Patient is capable of returning to work with no restrictions.

☐ Patient is capable of returning to work with restrictions. **(Complete Part 2)**

☐ I have reviewed Part 2 above and have determined that the Patient is totally disabled and is unable to return to work at this time.

Recommended date of next appointment to review Abilities and/or Restrictions: dd mm yyyy

PART 3 - Confirmation and Attestation

Health care Professional: The following information should be completed by the Health Care Professional

I confirm all of the information provided in this attestation is accurate and complete: ☐

Completing Health Care Professional Name: (Please Print)	
Date:	
Telephone Number:	
Signature:	

*"General Nature of Illness" (or injury) suggests a general statement of a person's illness or injury in plain language without any technical medical details, including diagnosis. Although revealing the nature of an illness may suggest the diagnosis, it will not necessarily do so. "Nature of illness" and "diagnosis" are not congruent terms. For example, a statement that a person has a cardiac or abdominal condition or that s/he has undergone surgery in
that respect reveals the essence of the situation without revealing a diagnosis.

Additional or follow up information may be requested as appropriate.