TRAC Group

Disability Management Solutions

ATTENDING HEALTHCARE PRACTITIONER STATEMENT

The **Employer** is self-insured for short term disability and sick leave benefits and the information requested below is vital to ensuring an Employee's eligibility for benefits during his/her absence from work.

In order to support the medical absence of this Employee and to facilitate his/her return to work, we kindly request completion of this form in full. For sections of the form that do not apply, please indicate: Not Applicable (N/A).

As an Employer, the **Employer** is committed to providing a transitional and/or modified work program for its personnel and we require your guidance to ensure a timely and safe return to work. ***TRAC Group*** and the **Employer's** Human Resources Department co-ordinate return to work efforts in collaboration with the Primary Care Provider, the Department Manager/Supervisor, and the Employee while respecting the privacy of Employees, in keeping with federal and provincial governing privacy legislation. Please visit: www.tracgroup.ca/privacy-policy for a copy of ***TRAC Group***'s Privacy Policy. *Please note: all costs associated with the completion of this form are the responsibility of the Employee.*

Section A: EMPLOYEE INFORMATION

Name _____ **DOB:** _____

Address _____ **City:** _____ **Postal Code:** _____

Phone (H): _____**(W):** _____ **First Date of Absence:** _____

Department: _____ **Manager/Supervisor:** _____

Section B: CONSENT INFORMATION: (To be completed by Employee)

I, _____hereby authorize _____to release personal health information requested in this form relating to the current nature of illness / injury only, to ***TRAC Group*** who will only share information pertaining to my limitations, restrictions and abilities with my Employer, the **Employer**. It is intended that the collection of the aforementioned information is to assist in any or all of the following:

- Determining my eligibility for a sick leave, short-term disability or income replacement benefit;
- Providing me with workplace accommodation (s);
- Managing my attendance;
- Managing my return-to-work from a medical leave; and
- Otherwise assess my fitness to perform my job duties.

I authorize you to communicate with a representative of ***TRAC Group*** to clarify any issues related to the personal health information you provide pursuant to this authorization. This authorization shall remain valid for the duration of my claim for benefits in relation to the current nature of illness/ injury. I confirm that a photocopy, facsimile or electronic copy of this authorization shall be as valid as the original.

This authorization is based upon my Employer's and ***TRAC Group***'s agreement that the information provided will be collected, stored and used in accordance with governing federal and provincial privacy legislation, and only for the purposes for which it was collected in relation to the current nature of illness/injury. I am aware that I may choose whether to provide or withhold this consent, but that my decision may affect my eligibility for sick leave or short-term disability benefits, my access to workplace accommodation(s) and/or my ability to return to regular or modified work duties.

Signed: _____ Dated: _____

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NOTE TO HEALTHCARE PRACTITIONER: Please complete either Section C, D, and E.

Section C: ILLNESS/INJURY INFORMATION

Nature of illness/injury:_____

_____

Date illness/injury began: _____**Date of examination by Health Care Practitioner:** _____

Anticipated duration of disability: _____

Have you scheduled a *follow up* appointment? ☐ **Yes** ☐ **No** **If yes, when?** _____

Is there a treatment plan currently in place? ☐ **Yes** ☐ **No** **If no, why?** _____

Is the Employee participating in the prescribed/recommended treatment plan? ☐ **Yes** ☐ **No**

Should this injury/illness be filed via WSIB? ☐ **Yes** ☐ **No**

_____

_____

Section D: ABILITIES

PHYSICAL ABILITIES ☐ **NOT APPLICABLE**

Walking (continuously):	☐ **up to 20 min;**	☐ **up to 1 hour;**	☐**no restrictions;**	☐ **other (e.g. uneven ground)** _____	
Standing (continuously):	☐ **up to 20 min;**	☐ **up to 1 hour;**	☐**no restrictions;**	☐ **other** _____	
Sitting (continuously):	☐ **up to 30 min;**	☐ **up to 1 hour;**	☐**no restrictions;**	☐ **other** _____	
Running/Jumping:	☐ **up to 30 min;**	☐ **up to 1 hour;**	☐**no restrictions;**	☐ **other** _____	
Lifting Floor to Waist:	☐ **up to 20 lbs;**	☐ **up to 30 lbs;**	☐ **up to 40 lbs;**	☐**no restrictions;**	☐ **other** _____
Lifting Waist to Shoulder:	☐ **up to 20 lbs;**	☐ **up to 30 lbs;**	☐ **up to 40 lbs;**	☐**no restrictions;**	☐ **other** _____
Pushing:	☐ **up to 20 lbs;**	☐ **up to 30 lbs;**	☐ **up to 40 lbs;**	☐**no restrictions;**	☐ **other** _____
Pulling:	☐ **up to 20 lbs;**	☐ **up to 30 lbs;**	☐ **up to 40 lbs;**	☐**no restrictions;**	☐ **other** _____
Above shoulder activity:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____	
Below shoulder activity:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____	
Stair Climbing:	☐ **unable;**	☐ **2-3 steps;**	☐ **own pace;**	☐ **assisted;**	☐**no restrictions;**
Bend/twist at waist:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____	
Bend/twist at knees:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____	
Neck motion:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____	
Crawling:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____	

Balancing: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Kneeling: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Employee is: ☐ Left handed; ☐ Right handed; ☐ Ambidextrous;

Limited ability to use left hand to: ☐ hold objects; ☐ grip; ☐ type; ☐ write;

Limited ability to use right hand to: ☐ hold objects; ☐ grip; ☐ type; ☐ write;

Completely unable to use left hand to: ☐ hold objects; ☐ grip; ☐ type; ☐ write;

Completely unable to use right hand to: ☐ hold objects; ☐ grip; ☐ type; ☐ write;

Forceful grip: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Work Hours per day: ☐ 4 hours ☐ 6 hours ☐ 8 hours ☐ 10 hours ☐ 12 hours

☐ No restrictions ☐ Less than 4 hours (specify) _____

COGNITIVE ABILITIES ☐ NOT APPLICABLE

Self-Supervision: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Ability to be Supervised: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Ability to Supervise: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Deadline Pressures: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Attention to Detail: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Exposure to Environmental Stimuli: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Working in Cooperation with Others: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Exposure to Confrontation: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Responsibility/Accountability: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Focus: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Memory: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Goal Setting: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Planning: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Organization: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Reasoning: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Problem Solving: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Insight/Self-Awareness: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Language: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

Time Management: ☐ limited capacity; ☐ unable to perform; ☐no restriction; ☐ other _____

SKILLS DEMAND ☐ **NOT APPLICABLE**

Reading/Computer Work:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____
Filing:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____
Handwriting/Paperwork:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____
Keyboarding:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____
Answering Phones:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____
Reading Literacy:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____
Written Literacy:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____
Numerical Skills:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____
Computer Literacy:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____
Equipment Operation:	☐ **limited capacity;**	☐ **unable to perform;**	☐**no restriction;**	☐ **other** _____

Date Employee is expected to return to full duties:_____

Is the Employee medically safe to participate in use of force training at the above noted date? ☐ Yes ☐ No

In your opinion, can the employee safely be in possession of a firearm or other use of force items (Taser, Pepper spray, Baton)? ☐ Yes ☐ No If no, please explain:

_____

_____

If the Employee cannot return to full duties, can the Employee return to work on modified duties? ☐ Yes ☐ No

If the above noted limitations/restrictions, as noted in categories above, can be accommodated in the workplace, is the Employee able to return to work immediately? ☐ Yes ☐ No

Recommendations, if any, for Accommodation: _____

_____

_____

Expected length of time accommodations/modifications will be required: _____

While the Employee is off work on sick leave, is the member able to attend court? ☐ Yes ☐ No

If no, please explain:

_____

_____

Section F: ATTENDING HEALTHCARE PRACTITIONER'S INFORMATION

Healthcare Practitioner's Name (please print): _____

Specialty: _____

Address: _____

Phone: _____ **Fax:** _____

Signature: _____ **Date:** _____

PLEASE FAX COMPLETED FORM TO:
FAX: 1.855.613.9997
For questions or clarification, please contact: Lisa Eyamie, CDMP
TF: 1-866-526-0877 ext. 35242
lisa.eyamie@tracgroup.ca