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Attending Practitioner Report

Part A – Employee Identification and Authorization

(to be completed by the employee)

Shift Worker NO YES 8 10 12

Name (last, first): _____ Status FT PT

Address: _____ Telephone: _____

First Day Absent: _____ Department: _____ Occupation _____

Manager: _____

I hereby authorize the practitioner, by completing and signing this form, to **release the medical/functional information below pertaining to my current medical absence**, to my employer. This information provided is for the purpose of determining my fitness to work and/or the need for any accommodations in my workplace and/or substantiating my absence due to illness or injury and/or eligibility for benefits.

MANDATORY Employee Signature: _____	Date: _____
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All medical information received will be kept in **strict confidence** in the employee's medical file.

Part B – Attending Practitioner's Report (to be completed ONLY by the practitioner)

The Ontario Medical Association (OMA) outlines in its "Position in Support of Timely RTW Programs and the role of the Practitioner", that practitioners should provide objective reports on impairment, medical restrictions and other supporting advice to the employee. Upon receipt of this information, RVHS will offer, when necessary, a modified or graduated, "Return to Work" program, time limited (4-6 wks) designed to facilitate the timely and safe return of employees who are recovering from injury or illness.

Type of Disability: Illness Injury

Nature of Illness/Injury (disclosure of diagnosis is not being requested): Primary/Secondary _____

Does the current illness or injury involve any of the following:

- A communicable disease?
- M.V.A.
- Workplace Injury
- A surgical matter OHIP-COVERED YES NO

Date of: First visit _____ Last visit _____ Planned follow-up _____

In my opinion, supported by objective medical evidence, the patient has been **totally disabled** OR has been **partially disabled**

From _____ To _____

Is a specialist referral required? No Yes

Is employee participating in active treatment, counseling, rehabilitation or therapy? No Yes Times per Week: _____

Does the employee require rehab services at RVHS? No Yes

Prognosis for Return to Work GOOD POOR UNCERTAIN

Expected return to work: Date: _____
 Regular Duties Modified Duties Duration _____
 Permanent restrictions Modified Hours Specify _____

Physical limitations:

- Lifting < 3 kgs
- Lifting < 10 kgs
- Pushing/Pulling
- Overhead Work
- Standing _____ Hours per Day
- Sitting _____ Hours per Day
- Bending/twisting of: _____
- Environmental exposure to: _____

Comments: _____

Practitioner's Name (please print) _____

Address _____

Phone _____ Fax _____

Family Physician? Yes No Specialist? (Indicate specialty) _____

Signature _____ Date _____

Practitioner's stamp
