nova scotia health authority

Occupational Health

Attending Physician's Report and Application for Sick Leave Benefits for NSGEU and Excluded Employees

All Nova Scotia Health Authority Employees are to send the form to:

Occupational Health
Purdy Building Room B40
300 Pleasant St., Dartmouth, N.S., B2Y 3Z9

Fax: (902) 473-2963 (dial 9 first, if faxing within QEII)
Alternate fax: (902) 425-7229
Phone: (902) 464-3081

Completed form must be returned to Occupational Health before 35/37.5/40 consecutive missed hours of work (prorated to designation and standard fulltime hours of work for the classification).

SECTION A – To be completed by employee (PRINT CLEARLY)

Last Name_____ First Name _____ Birth Date (YYYY/MM/DD) ____/____/____

Employee # _____ Home Phone #_____ Work Phone #_____

St Address _____ City_____ Postal Code _____

Job Title_____ Dept._____ Unit_____ Facility_____

Manager_____ Phone #_____ Union (NSGEU/NSNU) _____

Date of injury/illness (YYYY/MM/DD) ____/____/____ First Day of Absence (YYYY/MM/DD)____/____/____

Employment status: ☐ FT ☐ PT _____ ☐ Casual

AUTHORIZATION TO RELEASE INFORMATION TO NOVA SCOTIA HEALTH AUTHORITY

I authorize my **Attending/Consulting Physician** (Print physician name) _____ Phone #_____ to complete this report and release to my facility's Occupational Health Professional, any information relevant to this report for the purpose of determining my entitlement to sick leave benefits, to determine fitness to return to work on the understanding that all personal medical information will be kept confidential with only fitness to work information provided to my employer. The facility's Occupational Health may contact my physician for clarification of information.

Employee's Signature _____ **Date (YYYY/MM/DD)** ____/____/____

Home E-Mail required to communicate eligibility of claim_____

Is your illness/injury related to a Motor Vehicle Collision? ☐ Yes ☐ No

Is your illness/injury a result of a workplace incident? If YES, please have your Physician complete a WCB 810 form and you contact the SAFE line at 473-7233 (Do NOT fill out this form).

SECTION B – Health Care Provider to Complete (please print legibly)

First Assessment Date: (YYYY/MM/DD) ____/____/____ Today's Assessment Date: (YYYY/MM/DD) ____/____/____

Next Scheduled Assessment Date: (YYYY/MM/DD) ____/____/____

Nature of illness or injury causing absence from work, if more than one please list: 1)_____

2)_____ 3)_____ 4)_____

If pregnant, what is the expected date of confinement (EDC)? Date: (YYYY/MM/DD) ____/____/____

Has employee had same or similar condition in the past? ☐ Yes ☐ No

If Yes, please explain and note the date of the last occurrence:_____

Has employee been admitted to hospital? ☐ Yes ☐ No **If Yes,** Admission Date (YYYY/MM/DD) ___/____/____

Discharge Date (YYYY/MM/DD) ____/____/____

Did the employee have surgery? ☐ Yes ☐ No **If Yes,** Type of Surgery?_____

Date: (YYYY/MM/DD) ____/____/____

Is there a treatment plan specific to this illness/injury? ☐ Yes ☐ No _____

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

Has the employee been referred to another health care provider? ☐ Yes ☐ No **If Yes,** please indicate: _____

What was employee's response to treatment? (What further treatment is planned?) _____

Are there workplace factors contributing to absence or acting as barriers to recovery? ☐ Yes ☐ No

If Yes, please describe:

Patient's Name: _____

Would a workplace meeting be useful in addressing these workplace issues (recognizing, that if they are not addressed, they will not be resolved)? ☐ Yes ☐ No

Please provide information regarding any medications that have been prescribed for the above noted illness/injury only, if any.

Medications	Starting Date (YYYY/MM/DD)	Starting Dose	Current Dose	Response
1				
2				

Please indicate your patient's functional and or cognitive impairments during the **noted absence period:**

(Please note the following guidelines)

Slight impairment is one that causes minimal disruption and allows an individual to perform routine activities with some caution.

Moderate impairment is one that allows an individual to perform routine activities with modification (slower paced). A transient increase in symptoms may result.

Severe impairment is one that an individual performs with great difficulty and some risk to self or others.

Functional Limitations	Slight	Moderate	Severe	Cognitive Limitations	Slight	Moderate	Severe
Walk				Reading			
Stand				Concentration			
Sit				Decision Making			
Stair Climb				Handling Deadlines			
Ladder				Attending to Details			
Kneel				Problem Solving			
Reach- Above Shoulder				Self Supervision			
Reach- Below Shoulder				Supervising Others			
Push/Pull				Interact with Others			
Bend/Twist				Safety Sensitive Work			
Manual Dexterity				Understanding			
Writing				Memory			
Lifting (circle one)	Light – up to 20 lbs. Medium – up to 50 lbs. Heavy – over 50 lbs.			Hearing /Speech			

The CDHA supports modified work programs, in which the employee's hours and responsibilities are modified to their functional ability. The program is progressive in nature and is monitored by Occupational Health.

Is/are there any medical impediment(s) to the employee returning to work within the above-noted limitations?

☐ Yes ☐ No **If Yes, explain** _____

When do you anticipate a return to usual functional/cognitive abilities? Date: (YYYY/MM/DD) ____/____/____

Comments? _____

Physician's Name: _____ Signature: _____

Address: _____ Date: (YYYY/MM/DD) ____/____/____

Phone #: _____ Fax #: _____

ANY FEES FOR COMPLETING THIS FORM ARE THE RESPONSIBILITY OF THE EMPLOYEE.