Occupational Health Safety & Wellness- Nova Scotia Health

Treatment Provider Report- Application for Sick Leave, Leave of Absence for Health Reasons, Transitional Duties and/or Duty to Accommodate

Completed form must be returned to Occupational Health Safety & Wellness as per applicable Collective Agreements and Employment Guides (prorated to designation)

NSHA Employees are to fax or email this form to Occupational Health Safety & Wellness at the following:

Northern Zone Fax: (902) 896-8604 northernocchealthfax@nshealth.ca

Eastern Zone Fax: (902) 563-0033 easternocchealthfax@nshealth.ca

Western Zone Fax: (902) 681-5586 westernocchealthfax@nshealth.ca

Central Zone Fax: (902) 473-2963 occhealthfax@nshealth.ca

SECTION A – To be completed by employee (PLEASE COMPLETE IN FULL AND PRINT CLEARLY)

Employee Name & ID#_____ Birth Date (YY/MM/DD) ____/____/____ Email: _____

Phone #_____ Job Title_____ Dept./Unit_____ Facility _____

Employment Status: ☐ FT ☐ PT _____ ☐ casual Manager/supervisor_____

First Day of Absence (YYYY/MM/DD) ____/_____/_____

Is your illness/injury work related? ☐ Yes ☐ No **If Yes**, please have your Physician complete a WCB 810 form and you must report the incident by contacting the Provincial SAFE line at **1- 844 -717 -7233** and selecting the appropriate zone in which you work.

AUTHORIZATION TO RELEASE INFORMATION TO OCCUPATIONAL HEALTH

I hereby authorize by treatment provider _____ to release any information related to this illness/injury to the Occupational Health Safety & Wellness professional assigned to my claim for the purpose of; application for sick leave, transitional duties, accommodation and subsequent entitlement to benefits as per my Collective Agreement or Employment Guide.

Employee's Signature_____ Date (YYYY/MM/DD) _____/_____/_____

SECTION B – Treatment Provider to Complete (please print legibly)

Please note: NSHA will be offering suitable transitional duties based on all information provided by this certificate

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

Diagnosis: 1)_____ 2)_____ 3)_____

Has your patient had the same or similar condition in the past? ☐ yes ☐ no Date: _____

Treatment plan: _____

Medications (relevant to this illness/injury)	Starting Date (YYYY/MM/DD)	Starting Dose	Current Dose	Response

Section C- Functional & Cognitive limitations: This section should be completed by the treatment provider

Walking:	**Standing:**	**Sitting:**	**Lifting from floor to waist:**	**Lifting from waist to shoulder:**	**Stair/ladder climbing:**	☐Limited use of hand (s):
☐ Full abilities ☐ Up to 100 metres ☐ 100-200 metres ☐ Other	☐ Full abilities ☐ Up to 15 mins ☐ 15-30 mins ☐ Other	☐ Full abilities ☐ Up to 30 mins ☐ 30 mins-1 hour ☐ Other	☐ Full abilities ☐ Up to 10lbs ☐ 10-20 lbs ☐ Other	☐ Full abilities ☐ Up to 10lbs ☐ 10-20 lbs ☐ Other	☐ Full abilities ☐ Up to 5 steps ☐ 5-10 steps ☐ Other	Left Right ☐ Gripping ☐ ☐ Pinching ☐ ☐ Other ☐

☐ Bending, twisting Restricted/as tolerated ☐Limited Sustained/repetitive postures of (specify) _____ _____ _____ _____ ☐Limited Work at or above shoulder activity	Limited pushing/ pulling with: ☐ Left arm ☐ Right arm ☐ Other	☐ Reduced Hours: ☐ 4hrs/shift ☐6hrs/shift ☐8hrs/shift ☐10hrs/shift ☐full hours ☐No rotating schedule (select one) ☐Days ☐Evenings ☐nights	Special Considerations: ☐ Sit to stand as needed. ☐ Self-paced work. Take micro breaks as needed ☐ Alternate office/location ☐ Reduced exposure to distracting stimuli. ☐ No time sensitive tasks/deadlines ☐ Potential side effects from medications (please specify) ☐ Prescription medication prohibits driving/ equipment operation ☐ workplace meeting to address issues in the workplace (recognizing that if they are not addressed they will not be resolved) ☐ Other _____	**Cognitive/Psychological:** ☐ Difficulties performing simple and repetitive tasks ☐ Problems maintaining focus/concentration on the job ☐ Limited ability to perform complex and varied tasks ☐ Reduced energy and pace required for the job ☐ Difficulty maintaining healthy co-worker relationships ☐ Limited ability to perform safety sensitive tasks.

Additional Comments on limitations:

Anticipated return to full hours/duties: ____/____ /____

Follow-up appointment: ☐ None required ☐ As needed Date of next apt.: ____/____ /____

Treatment Provider Name:_____ Signature: _____

Date: ____/____/____ Phone#:_____ Fax_____