FAX: 416-242-1096
PH: 416-242-1000 x 82700
APR@HRH.CA

Attending Practitioner's Statement

To support an application for sick leave benefits or to support a workplace absence, please ask your healthcare professional to complete all sections (except for Section A – Employee Information & Consent) of this form. This information is vital to ensure eligibility to benefits and/or to support an absence from work. You are obligated to provide Humber River Health's Occupational Health, Safety & Wellness department ("**OHS**") with updates concerning your prognosis and your abilities as they relate to your job tasks. This initial report shall be provided to OHS in a timely manner, but ideally within 48 hours of any medical assessment. If you are aware of any delays in obtaining the information requested below, you must inform OHS promptly and must facilitate ongoing communication to assist in your successful return to work. If your illness or injury is a result of a workplace incident, do not use this form and instead contact OHS for guidance.

SECTION A: Employee Information & Consent (*to be completed by employee*)

Name (Last, First):	**Telephone (Home):**	**Telephone (Cell):**
Address:		**Email:**
Job Title:	**Department:**	**Site:**
Manager:	**Status:** ☐ FT ☐ PT ☐ TEMP/CASUAL	**Shift Worker:** ☐ NO ☐ YES ☐ 8 ☐ 10 ☐ 12
Last Day Worked:	**First Day Absent:**	

By completing and signing this form, I authorize the physician/practitioner to disclose information to Humber River Health's Occupational Health, Safety & Wellness department regarding my current or recent medical condition (illness/injury) by **completing all sections below**, and to release limitations/restrictions and/or functional information pertaining to my current absence to Humber River Health. This information is collected for the purpose of determining my fitness to work and/or the need for any required accommodation in the workplace and/or to substantiate my absence due to illness or injury and/or eligibility for benefits. In addition, I authorize Humber River Health's Occupational Health department to contact my healthcare practitioner for the development and implementation of any return to work plan, if required. I understand that a failure to sign this consent may impact my access to sick leave benefits or substantiated absence(s) from work.

Employee Signature:	**Date: (YYYY/MM/DD)**

All medical information received will be kept in **strict confidence** in the employee's medical file within Occupational Health.

SECTION B: *To be completed in full only by the attending healthcare practitioner or this form may be considered incomplete*

*Please complete this form to assist us in determining your patient's eligibility for sick leave due to total disability. The definition of total disability (as per HOODIP sick benefits plan) is "unable, due to injury or illness, to perform the regular duties pertaining to the occupation in which you participated immediately before becoming disabled". Please note that if your patient is not able to perform the regular duties of their job, we are able to provide modified work in most cases. Please complete **all sections** and return this form promptly to ensure continuation of wages and/or access to benefits for your patient. Please note that where dates are requested, a date must be provided or else the form may be considered incomplete and follow-up may be necessary.*

1. **Please identify the nature (but not diagnosis) of the current injury/illness causing absence from work:**

Please also check all applicable boxes:

☐ **A communicable disease potentially *reportable to Public Health***
☐ **Recurrent condition**
☐ **A surgical matter; OHIP covered ☐ YES ☐ NO**
☐ **Hospitalized/Bed Ridden from _____to _____**
☐ **Mental Health condition with recognized diagnosis under the DSM-V**
☐ **Workplace Injury**

2. **Date of first visit for current health issue: _____(YYYY/MM/DD) Planned follow-up date: _____(YYYY/MM/DD)**
3. **Is the information that you are providing based on an in-person examination of the patient and your application of any related tests or assessment tools? ☐ YES ☐ NO**
4. **Is the employee/patient under an active treatment plan (e.g. medication/physiotherapy/counseling etc.)? ☐ YES ☐ NO**
   a. **Is the patient actively participating in the recommended treatment plan? ☐ YES ☐ NO**
   b. **Is there further follow-up required or planned with respect to the treatment plan? ☐ YES ☐ NO**
   c. **Is the patient under treatment which may impair their judgment or ability to work safely? ☐ YES ☐ NO**

Please describe the treatment plan.

5. **Is the patient/employee presently under the care of a specialist? ☐ YES ☐ NO**
    a. **If no, has a referral occurred?** ☐ YES ☐ NO ☐ N/A
        i. **If yes, please provide the date the referral was provided to the patient:** _____(YYYY/MM/DD)
6. **Has the patient/employee missed work for the same or related condition in the past?** ☐ YES ☐ NO ☐ Unknown
7. **Based on your assessment and objective medical evidence, the patient/employee's prognosis to resume regular duties:**
   ☐ **Good** ☐ **Poor** ☐ **Uncertain** ☐ **Permanent restrictions required**
    a. **Return to regular duties on:** _____(YYYY/MM/DD) **b. Return to modified duties on:** _____(YYYY/MM/DD)

If the employee cannot return to work with restrictions and/or modified duties, please explain in the box below:

SECTION C: *To be completed in full by the attending healthcare professional or it may be considered incomplete*

Please note that Humber River Health supports a modified work program that promotes an employee's safe, early and healthy return to work (e.g. progressive or gradual return to work plan or hours; modified duties; additional supports). If your patient requires modified duties and we require more detail in order for us to return your patient to work in the above manner, then we may require further functional assessment/evaluations to better understand your patient's abilities. We appreciate you providing a detailed, complete response to support returning your patient to work as soon as possible.

PHYSICAL ABILITIES		<1 hr	1-2 hrs	2-4 hrs	5-6 hrs	>6 hrs
Sitting	☐ Full abilities	☐	☐	☐	☐	☐
Standing	☐ Full abilities	☐	☐	☐	☐	☐
Walking	☐ Full abilities	☐	☐	☐	☐	☐
Stair Climbing	☐ Full abilities	☐	☐	☐	☐	☐
Movements	☐ Full abilities	☐ No sustained forward Flexion	☐ No overhead or extended arm reach	☐No bending or twisting	☐No repetitive or sustained use of:	☐ No work below waist
Pushing/Pulling **(kg)**	☐ Full abilities	☐No push	☐ No Pull			
Lifting/Lowering **(kg)**	☐ Full abilities	☐No lifting / lowering	☐<5	☐5-10	☐11-20	☐>20
COGNITIVE ABILITIES If applicable, please comment						

Please provide any additional comments which may assist with understanding the medical restrictions above, and provide the anticipated duration of the medical restrictions listed above.

Please note that all requests for reimbursement of APR Forms must be submitted to Occupational Health within 90 days of the date of service.

Practitioner's Stamp	Practitioner's Name (*print*): _____ Professional Designation/Specialty (i.e. MD, Chiro, Physio, etc.) _____ Phone: _____Fax: _____