



MEDICAL CERTIFICATE OF DISABILITY (HOODIP 1980)

For use by all ONA represented employees who were hired prior to January 1, 2006

Send completed form marked "confidential" to: Employee Health
Joseph Brant Hospital
1245 Lakeshore Rd.
Burlington, ON L7S 1W7
OR: Fax: 905-681-4871

The information on this form is being collected by Employee Health for the purpose of adjudicating and making a recommendation to Joseph Brant Hospital ("Hospital") concerning eligibility for Short Term Disability benefits under the 1980 HOODIP.

Section A General Information

Employee Name: Job title:

Address: City Province Postal Code

Date of Birth: Date of employment: Last Day Worked:

Employee's Home Phone #: Work Phone #:

Are you currently engaged in any gainful occupation? Yes No
If yes, please explain:

Section B Consent Information (To be completed by employee)

I authorize my treating, medically qualified health care professional (Name) to provide

Employee Health with information relative to my claim, by completing Section C. Medical information will be kept confidential by Employee Health and not disclosed to any other individual unless required by law. I understand that the Hospital will be notified concerning my eligibility for benefits and will be provided with information relevant to my return to work and accommodation. I accept a photocopy or other reproduction of this authorization is as valid as the original.

Employee's Signature: Date:

Section C - Disability Information (To be completed by Employee's Physician or other Qualified Medical Health Care Professional)

In order to support the medical absence of this employee and to facilitate his/her return to work we require specific information. Joseph Brant Hospital is committed to providing a transitional-modified work program for its personnel and requires your guidance to ensure a timely and safe return to work. This certificate will be deemed incomplete unless all information requested under Section C is complete.

1. Please identify the general nature of the illness or injury (without diagnosis or symptoms).

2. History

Symptoms began or accident happened on: / /
DD MM YY

First visit: / /
DD MM YY

Illness or injury forced cessation of work on: / /
DD MM YY

Is this a work-related illness-injury? Yes No
If yes, submit a Form 8 to WSIB

3. Current findings

Did you undertake an objective medical assessment that supports the illness/injury? Yes No

On what date did you make this medical assessment? / /
DD MM YY

Is there further assessment required?
 Yes No

If yes, date of Next visit:
 / /
DD MM YY

Is your patient capable of performing the regular duties of the occupation in which he/she participated immediately before becoming disabled? Yes No

If "No", please comment:

4. Treatment

Is your patient undergoing treatment? Yes No

5. Prognosis

Estimated date of return to full duties on a full time basis. / /
DD MM YY

With modifications to the employee's work or environment would the employee be able to return to work at an earlier date? Yes No

If "Yes", please estimate date of return to modified work : _____

The employer has a well-established comprehensive modified work program. Please outline your patient's functional capacity and restrictions so that an appropriate return to work plan can be developed.

Please provide any other pertinent details about the return to work plan.

Notice to physician and/or other qualified medical health care professional: Any information provided by you to Employee Health may be disclosed to the patient and/or those authorized by him/her to receive such disclosure.

Joseph Brant Hospital will pay the fee for completion of this form upon presentation of an original receipt. Receipts may be mailed to: Employee Health, Joseph Brant Hospital, 1245 Lakeshore Rd., Burlington, ON, L7S 0A2

Physician's signature: _____

Date / /
DD MM YY

Print name: _____ Phone number () _____

Optional Voluntary Consent

The following additional confidential medical information is requested because it may assist in the determination of your eligibility for HOODIP sick benefits. You are under no obligation to consent to the release of any of the information requested in this section. You can decline to consent to the release of any of it, or you can consent to the release of some or all of it. All of this additional medical information will be kept confidential by Employee Health. It will not be disclosed to anyone else without your further specific written consent.

I authorize my attending physician or other treating medically qualified healthcare professional, _____ to complete this form and to provide to Employee Health the following information (Name)
(Please check all that apply)

Diagnosis

Current Findings

Referrals

Treatment

I understand that such disclosure is totally voluntary.

Employee's Signature: _____

Date: ____/____/____
DD MM YY

1. Diagnosis

Primary: _____ Symptoms: _____

Secondary: _____ Symptoms: _____

Other contributing factors-complications: _____

2. Current findings

What were your findings based on the examination(s) of this patient? (Please describe)

3. Referrals

Specialists:

Has the patient been referred to a Specialist? Yes No

If so, what is the Specialist's name and Specialty? Name: _____

Specialty: _____

Has a consult with a Specialist been scheduled? Yes No Date of Appointment? ____/____/____
DD MM YY

Has the Specialist provided you with a report? Yes No

If yes, please describe the findings.

Tests: (eg. EKG, MRI, X-rays, Lab)

4. Treatment

Please provide a detailed description of all treatment prescribed to date and a description of the treatment plan.

Is your patient compliant with the treatment? ___ Yes ___ No

If your patient is not compliant, is there a medically supported basis for non-compliance? ___ Yes ___ No

What has been the response to treatment? †Regression †No Change †Minimal †Significant †Full Recovery

If the response to treatment has not been adequate, had the treatment plan been revised? ___ Yes ___ No

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Physician's signature: _____

Date / /
DD MM YY

Print name: _____ Phone number () _____