JOSEPH BRANT HOSPITAL

MEDICAL CERTIFICATE OF DISABILITY (HOODIP 1992)

For use by all Non-Union, OPSEU and CUPE represented employees, and ONA represented employees (ONA hired after January 1, 2006).

Send completed form marked "confidential" to:

Employee Health
Joseph Brant Hospital
1245 Lakeshore Rd.
Burlington, ON L7S 0A2
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 1992 HOODIP.

Section A General Information

Employee Name: _____ Job title: _____

Address:_____
City Province Postal Code

Date of Birth:___/___/___ Date of employment: ___/___/___ Last Day Worked: ___/___/___
DD MM YY DD MM YY DD MM YY

Employee's Home Phone #: ( ) _____ Work Phone #: ( ) _____

Section B Consent Information (To be completed by employee)

I authorize my treating, medically qualified health care professional _____ to provide
(Name)
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: ___/___/___
DD MM YY

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: ___/___/__ First visit: ___/___/___
DD MM YY DD MM YY

Illness or injury forced cessation of work on: ___/___/__ Is this a work-related illness-injury? ____Yes ____No
DD MM YY **If yes, submit a Form 8 to WSIB**

JOSEPH BRANT HOSPITAL

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 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 the employee under active, continuous and medically appropriate care for his/her disability? ____Yes ____No

Please provide a description of the treatment plan.

_____

_____

_____

Is your patient compliant with the treatment? ____Yes ____No

If your patient is not compliant, is there medically supported basis for non-compliance? ____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 ( ) _____

JOSEPH BRANT HOSPITAL

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 any other individual 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**

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.

_____

_____

_____

JOSEPH BRANT HOSPITAL

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

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 ( ) _____