Application for Short Term Disability Leave (STD) – Package A

*(*All Staff, CUPE 145, Cupe 815, SEIU, OPSEU and **ONA union employee** employed by HHS **after** January 2, 2006)*

Dear Employee:

When absent from work due to a sickness for four (4) consecutive shifts, employees are required to apply for Short Term Disability (STD) under the Hospitals' of Ontario Disability Insurance Plan (HOODIP). The attached Healthcare Practitioners Statement (HCPS) is designed to collect the information necessary to determine an employee's eligibility for STD and is also used for return to work planning.

In order to be eligible for Short Term Disability, the employee must demonstrate they meet the specific criteria set out in the disability insurance plan.

Key Information for Employees:

- This document must be completed in **full** and must provide an **objective assessment** of your impairment including the functional limitations that exist due to your illness or injury. Where you are only partially disabled, and your needs can be safely accommodated through modifications to your job, STD leave will be adjudicated in collaboration with the Early and Safe Return to Work Program.
- You must be under the active and continuous care of a physician or other licensed professional satisfactory to your employer, and be following the prescribed treatment plan.
- The hospital will reimburse you for a required HCPS where all sections have been fully completed upon submission of a paid receipt: **it is your responsibility to ensure the information is complete and provided to Health, Safety & Wellness within 10 days of your first day absent.**
- You will be informed by the Disability Specialist in Health, Safety and Wellness (HSW) whether your STD Claim has been approved and for what period of time.
- Failure to provide the initial or subsequent HCPS required thereafter to support ongoing disability will result in the STD leave (paid or unpaid) not being approved.
- If this is a **Work Related Injury/Illness** you must contact HSW at ext. 4611 immediately
- **THIS FORM SHOULD NOT BE PROVIDED TO YOUR MANAGER/SUPERVISOR.**

All medical information received is handled in a confidential manner and retained in the employee's confidential medical record in HSW. Information shared outside of HSW is limited to work abilities/accommodation needs.

Healthcare Practitioners Statement – Form A

*(*All Staff, CUPE 145, Cupe 815, SEIU, OPSEU and **ONA union employee** employed by HHS **after** January 2, 2006)*

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

Name: _____ Job Title: _____
Address: _____ City: _____ Postal Code: _____
Phone: _____ Manager/Supervisor: _____ Phone: _____
LAST DAY WORKED: _____ **FIRST MISSED SHIFT:** _____

SECTION B ***Consent: (to be completed by employee)*** I consent to allow Health, Safety and Wellness to provide information related to my fitness for work and any accommodation needs to my manager/supervisor and Union Representative (if applicable).

_____
Signature Date

SECTION C ***(to be completed by qualified medical doctor or qualified mental health professional)***)

Dear Doctor: Your patient is applying for Short Term Disability (STD) under the **Hospitals' of Ontario Disability Insurance Plan (HOODIP).** Please provide **an accurate and objective assessment of the employee's impairment(s) in relation to their illness/injury.** By completing this form you are certifying that the information is true and is in keeping with professional standards outlined by the professional and regulatory bodies that govern your practice. You further understand that all information requested must be **fully** completed to ensure the employer can determine the employee's eligibility for salary replacement benefits. **Incomplete forms will be provided back to your patient to facilitate completion.**

Have you reviewed the above statement? ☐ YES ☐ NO

Is the Injury/Illness work related? Yes (Complete WSIB Form 8) No

Date first incapable of working: _____

Date first assessed to be totally disabled from all duties of: _____

Specified period of absence: _____ (total disability)

Nature of illness or injury: _____ (no diagnosis)

Employee is under your active, continuous and medically appropriate care: _____
_____

Please describe treatment provided: _____
_____
_____

Please describe treatment plan:
_____
_____

Prognosis/Return to work date: _____Have you discussed modified work with the employee? _____

Complete recovery expected: _____Employee is compliant with treatment: _____

SECTION D: Please select one in reference to ***pre-injury position***, applicable to your selection

☐ Patient is capable of returning to work with *no restrictions*.	☐ Patient is capable of returning to work with *modified duties* **Please complete full form.**	☐ Patient is capable of returning to work with *modified hours* **Please complete full form.**	☐ Patient is physically *unable* to return to work at this time. **Please complete full form with current abilities.**

If yes to modified hours, please comment recommendation below:

Modified Hours details:	Graduate Hours details:	Start Date: _____ DD/MM/YYYY

Please indicate ***Physical Abilities:***

L: Left Side	R: Right Side	B: Both sides	
5 kg= 11lbs	10 kg = 22lbs	25kg = 55lbs	
Frequently: 34-66% of shift	Occasionally: 6-33% of shift	Rarely: 1-10% of shift	NOTE: Shifts vary from 8-12 hours

Walking: ☐ Full Abilities ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Specific:_____	Standing: ☐ Full Abilities ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Specific:_____	Sitting ☐ Full Abilities ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Specific:_____
Lifting - floor to waist: L / R / B ☐ Full Abilities ☐ Up to 5kg ☐ 5-10kg ☐ 11-25kg ☐ Specific:_____	Lifting - waist to shoulder: L / R / B ☐ Full abilities ☐ Up to 5kg ☐ 5-10kg ☐ 11-25kg ☐ Specific:_____	Travel to Work: ☐ Ability to use public transit ☐ Ability to drive car

Please indicate **Modifications** that apply:

Bending/Crouching ☐ Full Abilities ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Specific:_____	Work at/above shoulder: L / R / B ☐ Full Abilities ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Specific:_____	Chemical & Environmental Exposure: ☐ No Limitation ☐ No exposure to (e.g. Heat, Cold, Noise, Scent, Chemical): _____ _____ _____
Limited Use of Hand: L/ R / B ☐ Not Applicable ☐ Gripping ☐ Pinching ☐ Typing ☐ Writing ☐ Specific: _____	Limited Pushing/Pulling with: ☐ Not Applicable ☐ Left Arm ☐ Right Arm Please specify weight and duration: _____ _____ _____	Kneeling / Crawling / Climbing: ☐ Full Abilities ☐ Frequently ☐ Occasionally ☐ Rarely ☐ Specific:_____ ☐ Potential side effects from medications related to this injury/illness. **(Please do not include names of medications)** _____ _____

Please indicate ***Cognitive Abilities:***

COGNITIVE/BEHAVIOURAL:					
14. Self-Supervision	☐ Full Abilities	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Specify _____
1. Work with others:	☐ Full Abilities	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Specify _____
2. Work with public:	☐ Full Abilities	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Specify _____
3. Meet time pressure:	☐ Full Abilities	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Specify _____
4. Focus/Concentration:	☐ Full Abilities	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Specify _____
5. Ability to multi-task:	☐ Full Abilities	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Specify _____
6. Memory/Understanding:	☐ Full Abilities	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Specify _____

Additional Comments on Abilities, Modifications, and Modified/Graduated Return to work hours:

_____
_____
_____
_____
_____
_____
_____

From the Date of Assessment the above will apply for:

☐ 1-2 Days

☐ 3-7 Days

☐ 8-14 Days

Date of next assessment to review abilities and modifications: _____

DD/MM/YYYY

By affixing my signature below, I certify that I am a qualified medical doctor or a qualified mental health professional and that I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.

LICENSED HEALTHCARE PROVIDER: (Please Print)_____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

SIGNATURE: _____ ***DATE:*** _____

Once completed please return by fax to the number indicated below:

Halton Healthcare, Health, Safety & Wellness

3001 Hospital Gate, Oakville, ON L6M 0L8

Tel: 905-845-2571 ext. 4611 · **Fax: 905-815-5137**