The City of Hamilton

Forward Completed Form to:
Return to Work Services
Human Resources
City Hall, 71 Main Street West
HAMILTON ON L8P 4Y5 Fax (905) 546-4174

Personal information contained on this form is collected under the authority of the Municipal Act, R.S.O. 1990, c. M.45, and will be used a) by Return to Work Services to determine eligibility for short term disability benefits and b)Return to Work Services to evaluate work accommodation alternatives. Questions about this collection should be directed to the Director of Human Resources.

CUPE 5167 – LODGES; Claim form - Income Protection Benefits (Short Term Disability)

Instructions:
1. Please Print.
2. Part 1 to be completed by patient.
3. Part 2 to be completed by physician.
4. Any charge for completing this form is the patient's responsibility.
5. Following the claims decision, this document will be forwarded to Return to Work Services and will become part of the employee's confidential health record separate from the employee's personnel file.
6. Claims Forms are required to be submitted as per the Collective Agreement or otherwise as directed by the Employer.
7. Both Part 1 and 2 must be completed **in full** before S.T.D. payments can be authorized

PART 1 EMPLOYEE STATEMENT - TO BE COMPLETED PRIOR TO SUBMITTING TO PHYSICIAN (please print)

1. Name:	Department:	Employee No:
2. Start of Present Absence: (day/month/year)	Is This Absence a Result of a Workplace Accident/Incident? [ ] Yes [ ] No	
3. Occupation/Title:	Physical Effort Required: [ ] light [ ] moderate [ ] heavy	

Employee Authorization: The above information is accurate to the best of my knowledge, and I hereby authorize my physician to release the following and subsequent information to Return to Work Services in respect to my claim for short term disability benefits. **I further agree to the recovery of sick benefits received in the amount of 20% per pay cheque if it is found that the functional information provided does not support an absence from work.**

Employee Signature Date: (day/month/year)

PART 2 ATTENDING PHYSICIAN'S STATEMENT (incomplete information will result in the employee being non-paid) (please print)

1. To the best of your knowledge: a) indicate when symptoms first appeared or accident happened (day/month/year)	b) has patient had same or similar condition [ ] No [ ] Yes, please state when and describe
2. Is condition due to injury or sickness arising out of patient's employment: [ ] Yes [ ] No [ ] Unknown	
3. Date of hospital in-patient admission (day/month/year)	Date of discharge (day/month/year)
4. Nature of treatment (e.g. date and type of surgery)	
5. a) If patient was referred to you, give name of referring physician	b) If you have referred patient to a specialist, give name(s) of physicians
6. a) Date of first visit during present period of absence from work (day/month/year)	b) Date of latest attendance (day/month/year)

c) Were you actively supervising this patient's care during the full period
[ ] No, comment in remarks
[ ] Yes, state frequency of visits [ ] Weekly [ ] Monthly [ ] Other (specify)

7. a) To the best of my knowledge, indicate period patient has been unable to work at own occupation as a result of present condition
From (day/month/year) To (day/month/year) inclusive

b) If still unable to work, give apprx. date patient should be able to return **OR** the estimated number of weeks before possible return

(day/month/year)

8. The Employer has a proactive work accommodation policy. In light of your response to Part 2 No. 7, above, is this employee capable of performing their regular or modified duties at the present time?

[ ] A. Employee is/was fit to work without restriction on: _____ (date)

[ ] B. Employee is/was fit to work with the following medical restrictions on : _____ (date) Complete Restrictions Below

[ ] C. Employee is unfit to work. Complete Restrictions Below

Prognosis for [ ] Full recovery _____ (date) or [ ] Possible return to modified duties: _____ (date)

Physical Restrictions: (note weight and/or frequency restrictions and their estimated duration)

[ ] Lifting: _____
[ ] Walking: _____
[ ] Carrying: _____
[ ] Work at heights/reaching: _____
[ ] Pushing/Pulling: _____
[ ] Prolonged standing: _____
[ ] Vision: _____
[ ] Sitting: _____
[ ] Typing: _____
[ ] Climbing: _____
[ ] Bending: _____
[ ] Looking up: _____
[ ] Repetitive movements _____
[ ] Kneeling: _____
[ ] Cardiac: _____
[ ] Other: _____

Cognitive/Psychosocial Restrictions:

[ ] Analyze and reason:	**[ ] Mild [ ] Moderate [ ] Severe**	**Estimated Duration:**
[ ] Sustain concentration:	**[ ] Mild [ ] Moderate [ ] Severe**	_____
[ ] Memorize:	**[ ] Mild [ ] Moderate [ ] Severe**	_____
[ ] Interact with others:	**[ ] Mild [ ] Moderate [ ] Severe**	_____
[ ] Perform multiple tasks:	**[ ] Mild [ ] Moderate [ ] Severe**	_____
[ ] Other:	**[ ] Mild [ ] Moderate [ ] Severe**	_____

Additional Comments:

_____
_____
_____

9. Remarks - Please provide comments and further details which you feel would be helpful

Name of Attending Physician (please print)	Specialty	Telephone No.
Address (number, street, city, province, postal code)		
Signature	Date (day/month/year)	