The City of Hamilton CUPE 5167 Claim Form – Income Protection Benefit
(Short Term Disability and Functional Form)

Instructions:

1. Please complete in full and submit to: **Return to Work Services Fax: 905-546-4174 or Email: rtws@hamilton.ca**
2. Any charge for completing this form is the Employee's responsibility.
3. The Claim Form must be completed on or before the 8th working day of absence. The Employee will not receive Short Term Disability benefits past the thirteenth (13th) day if the Employer is not in receipt of a Claim Form substantiating their absence.
4. Employees may be required to provide additional medical information where reasonably necessary to determine eligibility for benefits or to evaluate work accommodation alternatives.
5. It is the Employee's responsibility to follow up to ensure the completed Claim Form is received by Return to Work Services.
6. Part 1 and Part 2 must be completed in full before Short Term Disability benefits can be authorized.

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

Name:	Department:	Employee No.: Phone:
Occupation/Title:	Personal Email Address:	
Start of Present Absence (day/month/year):	Is This Absence a Result of a Workplace Accident/Incident? ☐ Yes ☐ No	

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

Employee Signature: **Date: (day/month/year)**

PART 2: ATTENDING PHYSICIAN'S STATEMENT (please print)

1. To the best of your knowledge indicate when symptoms first appeared or accident happened (day/month/year):

2. Is condition due to injury or illness arising out of the patient's employment: ☐ Yes ☐ No ☐ Unknown
If Yes, has a WSIB FORM 8 been completed? ☐ Yes ☐ No

3. For Hospitalizations please give:
Date of in-patient admission (day/month/year): | Date of discharge (day/month/year):

4. Nature of treatment:
- ☐ Medication – Date Commenced: _____
- ☐ Counselling – Date Commenced: _____ Referral Date: _____
- ☐ Surgery – Date Commenced: _____
- ☐ Physical Rehabilitation – Date Commenced: _____ Referral Date: _____

If no treatment is indicated, please explain:

5. Has there been a referral to a Specialist? List name(s) of physician and date referred:

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) Have you actively supervised this patient's care during the full period of absence?
- ☐ No, please provide reasons in remarks area
- ☐ Yes, state frequency of visits ☐ Weekly ☐ Bi Weekly ☐ Monthly ☐ Other (specify)

d) Next scheduled appointment (day/month/year): _____

Remarks:

7. Please identify how you confirmed the current medical condition?
- ☐ Physical Examination
- ☐ Test Results
- ☐ Counselling Reports
- ☐ Other (please specify):
- ☐ Mini Mental Status Examination
- ☐ Validated Questionnaires
- ☐ Specialist Consultation Reports

Any additional Comments:

RETURN TO WORK STATUS

☐ Employee may return to full duties without restrictions/limitations (day/month/year):

The City of Hamilton has a proactive modified work program. The information provided below will be used to develop a return to work plan for your patient. Even if your patient is totally disabled, please provide current abilities, limitations and restrictions which explains their inability to work in any capacity.

☐ Employee may return to modified duties (day/month/year): _____ (complete tables below)

☐ Employee is unable to return to work in any capacity (complete tables below)

Prognosis for full recovery (day/month/year): _____ or

Possible return to modified duties (day/month/year): _____

PHYSICAL ABILITIES – Please indicate the patient's abilities

Walking: ☐ Full Abilities ☐ Up to 100 meters ☐ 100 - 200 meters ☐ Other (please specify)	Standing: ☐ Full Abilities ☐ Up to 15 minutes ☐ 5 - 30 minutes ☐ Other (please specify)	Sitting: ☐ Full Abilities ☐ Up to 30 minutes ☐ 30 minutes - 1 hour ☐ Other (please specify)	Lifting from Floor to Waist: ☐ Full Abilities ☐ Up to 5 kilograms ☐ 5 – 10 kilograms ☐ Other (please specify)
Lifting from Waist to Shoulder: ☐ Full Abilities ☐ Up to 5 kilograms ☐ 5 – 10 kilograms ☐ Other (please specify)	Stair Climbing: ☐ Full Abilities ☐ Up to 5 steps ☐ 5 – 10 steps ☐ Other (please specify)	Ladder Climbing: ☐ Full Abilities ☐ 1 – 3 steps ☐ 4 – 6 steps ☐ Other (please specify)	Kneeling: ☐ Full Abilities ☐ No Ability ☐ Other (please specify)
Able to Use Public Transit ☐ Yes ☐ No	Able to Drive Car? ☐ Yes ☐ No		

RESTRICTIONS – Please indicate any physical Restrictions that apply

☐ Bending/twisting/ repetitive movement of (please specify) ☐ Work at or Above Shoulder Activity	Limited Pushing/Pulling with: ☐ Left arm ☐ Right arm ☐ Other (please specify)	Limited Use of Hands: Left Right ☐ Grip ☐ ☐ Pinch ☐ ☐ Other ☐	Exposure to Vibration: ☐ Whole Body ☐ Hand/Arm ☐ Other (please specify)
☐ Operating motorized equipment (e.g., company vans, maintenance equipment, other	☐ Potential Side Effects from Medications (please specify)	☐ Chemical Exposure to (please specify)	

Any additional comments:

COGNITIVE ABILTIIES – Please indicate the patient's abilities

Supervision of Others: ☐ No restrictions ☐ Unable to supervise	Tolerance of Deadlines: ☐ No restrictions ☐ Can deal with strict deadlines ☐ Can deal with recurring deadlines ☐ Can deal with occasional deadlines ☐ Cannot deal with deadlines	Attention to Detail: ☐ No restrictions ☐ Can concentrate on detail with occasional breaks of non-detail work ☐ Concentration on detail slightly limited ☐ Concentration on detail severely limited	Task Responsibility and Independence: ☐ No restrictions ☐ Require allowance to leave work and access a quiet area as needed ☐ Must work with a partner or be restricted to job shadowing ☐ Unable to take primary responsibility for completing tasks
Ability to Cope with Confrontational Situations: ☐ No Restrictions ☐ Moderate ability to cope with confrontational situations ☐ Unable to cope with confrontational situations	Performance of Multiple Tasks: ☐ No Restrictions ☐ Can handle multiple tasks but may require additional time ☐ Can handle more than one task, but a limited number only ☐ Can deal with only one task at a time	Memory: ☐ No Restrictions ☐ Has basic memory ability (i.e., can recall information that is applied to work tasks on a regular basis without rigid time constraints) ☐ Poor memory recall of information	Cognitive Demands (select all that apply) ☐ Capable of analytical thinking ☐ Capable of making sound judgment ☐ Able to take initiative ☐ Able to problem solve and make decisions ☐ Able to attain precise limits/standards

Any additional comments:

ATTENDING PHYSICIAN'S INFORMATION

Name of Attending Physician (please print):	Specialty:
Phone No.:	Fax No.:
Address (Number, Street, city, province, postal code):	
Physician Signature:	Date of Examination (day/month/year):