Capital Health

Occupational Health

Leave of Absence for Health Reasons Application (NSGEU & Exclusions)

All Capital Health Employees are to send the form to:

Occupational Health
Purdy Building, Room B41D
300 Pleasant St., Dartmouth, NS, B2Y 3Z9

Fax: (902) 473-2963 (dial 9 first, if faxing within QEII)
Alternate fax: (902) 461-8073
Phone: (902) 464-3081

SECTION A – To be completed by employee (PRINT CLEARLY)

Last name _____ First name _____ Birth date (YYYY/MM/DD) ____/___/___
Employee # _____ Home phone # _____ Work phone # _____
St address _____ City _____ Postal code _____
Job title _____ Dept. _____ Unit _____ Facility _____
Manager _____ Phone # _____ Union (NSGEU) _____
Date of injury/illness (YYYY/MM/DD) _____/___/___ First day of absence (YYYY/MM/DD) _____/___/___
Employment status: ☐ FT ☐ PT _____ ☐ Casual

AUTHORIZATION TO RELEASE INFORMATION TO CAPITAL HEALTH

I authorize my **attending/consulting Physician** (Print name) _____ Phone # _____ to complete this report and release to my facility's Occupational Health Professional, any information relevant to this report for the purpose of determining my entitlement to Leave of Absence for Health Reasons, to determine fitness to return to work, and assist in rehabilitation; on the understanding that all personal medical information will be kept confidential with only fitness to work information provided to my employer. The facility's Occupational Health Care Professional may contact my physician for clarification of information.

Employee's signature _____ Date (YYYY/MM/DD) _____/___/___

Is your illness/injury related to a Motor Vehicle Collision? ☐ Yes ☐ No
Is your illness/injury work related? ☐ Yes ☐ No **If Yes**, please call 473-SAFE (7233) to apply for Worker's Compensation.

After receiving completed form, Occupational Health will contact your manager with the return to work date.

SECTION B – Health Care Provider to complete (please print legible)

First assessment date (YYYY/MM/DD) _____/___/___ Today's assessment date (YYYY/MM/DD) _____/___/___
Next scheduled assessment date (YYYY/MM/DD) _____/___/___
Nature of illness or injury causing absence from work; if more than one please list: 1) _____
2) _____ 3) _____ 4) _____
Has employee had same or similar condition in the past? ☐ Yes ☐ No
If Yes, please explain and note the date of the last occurrence: _____

Is there a treatment plan specific to this illness/injury? ☐ Yes ☐ No _____
Is the employee following the recommended treatment plan? ☐ Yes ☐ No _____
Has the employee been referred to another health care provider? ☐ Yes ☐ No If Yes, please indicate _____
What was employee's response to treatment? (What further treatment is planned?) _____
Are there workplace factors contributing to absence or acting as barriers to recovery? ☐ Yes ☐ No
If Yes, please describe: _____

Patient's name: _____

Would a workplace meeting be useful in addressing these workplace issues (recognizing, that if they are not addressed, they will not be resolved)? ☐ Yes ☐ No

Please provide information regarding any medications that have been prescribed for the above noted illness/injury only, if any.

Medications	Starting date (YYYY/MM/DD)	Starting dose	Current dose	Response
1				
2				

Please indicate your patient's functional and/or cognitive impairments during the **noted absence period**:
(Please note the following guidelines)

Slight impairment is one that causes minimal disruption and allows an individual to perform routine activities with some caution.

Moderate impairment is one that allows an individual to perform routine activities with modification (slower paced). A transient increase in symptoms may result.

Severe impairment is one that an individual performs with great difficulty and some risk to self or others.

Functional Limitations	Slight	Moderate	Severe	Cognitive Limitations	Slight	Moderate	Severe
Walk				Reading			
Stand				Concentration			
Sit				Decision making			
Stair climb				Handling deadlines			
Ladder				Attending to details			
Kneel				Problem solving			
Reach – above shoulder				Self supervision			
Reach – below shoulder				Supervising others			
Push/Pull				Interact with others			
Bend/Twist				Safety sensitive work			
Manual dexterity				Understanding			
Writing				Memory			
Lifting (circle one)	Light - up to 20 lbs. Medium - up to 50 lbs. Heavy - over 50 lbs.			Hearing/Speech			

The CDHA supports modified work program, in which the employee's hours and responsibilities are modified to their functional ability. The program is progressive in nature and is monitored by Occupational Health.

Is/are there any medical impediment(s) to the employee returning to work within the above-noted limitations?

☐ Yes ☐ No **If yes, please explain**: _____

_____

Do you anticipate these restrictions to be temporary or permanent? _____

If temporary, please indicate time frame for resolution of above restrictions. _____

When do you anticipate a return to usual functional/cognitive abilities? Date (YYYY/MM/DD) _____/___/___

Comments _____

_____

Physician's name _____ Signature _____

Address _____ Date (YYYY/MM/DD)_____/___/___

Phone # _____ Fax # _____

ANY FEE FOR COMPLETING THIS FORM IS THE RESPONSIBILITY OF THE EMPLOYEE