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:

- The HCPS 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.**
- You will be informed by the Disability Specialist in Health, Safety and Wellness 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.
- For more information please contact Health, Safety & Wellness or your Manager.
- If this is a **Work Related Injury/Illness** you must apply to the Workplace Safety and Insurance Board for Benefits, and complete an Incident Report through the electronic IRS System at Halton Healthcare.
- **THIS FORM SHOULD NOT BE PROVIDED TO YOUR MANAGER/SUPERVISOR.**

Dear Physician:

Your patient is applying for Short Term Disability (STD) under the **Hospitals' of Ontario Disability Insurance Plan.** Please provide the nature and date of onset of their illness/injury, a description of the treatment they are receiving, and **an accurate and objective assessment of the employee's impairment(s) in relation to their illness/injury.**

While we depend on the employee's health care practitioner to identify their functional abilities, decisions regarding an employee's eligibility for STD benefits, as well as whether and where their work can be modified to accommodate their abilities, rests with the employer. Should you have any questions about our Early and Safe Return to Work program please contact us at 905-845-2571 ext. 4611.

All medical information received is handled in a confidential manner and retained in the employee's confidential medical record in Health, Safety & Wellness. Information shared outside of Health, Safety & Wellness 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: Please be advised that by completing this form you are certifying that the information is true and accurate 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.

Is the Injury/Illness work related? Yes 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: _____

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 restrictions. **Please complete full form.**	☐ Patient is physically unable to return to work at this time. **Please complete full form with current abilities.**

Recommendation for working hours and start date:

☐ Full Hours	☐ Modified Hours **Please provide details in comments**	☐ Graduate Hours **Please provide Details in comments**	Start Date: _____ DD/MM/YYYY

Please indicate ***Abilities*** that may apply:

Walking: ☐ Full Abilities ☐ Up to 100 meters ☐ 100-200 meters ☐ Other **(Please Specify)**	Standing: ☐ Full Abilities ☐ Up to 15 minutes ☐ 15-30 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 5kg ☐ 5-10kg ☐ Other (**please specify)**	Lifting from waist to shoulder: ☐ Full abilities ☐ Up to 5kg ☐ 5-10kg ☐ Other (**please specify)**	Travel to Work: ☐ Ability to use public transit ☐ Ability to drive car

Please indicate **Modifications** that apply:

Bending/Twisting/Repetitive Movement: ☐ No Limitation ☐ Limited (**Please Specify below)** _____ ☐ No Bending/twisting/repetitive movement	Work at or above shoulder: ☐ No limitation ☐ Limited, specify weight and duration below: _____ ☐ No work at or above shoulder level.	Chemical & Environmental Exposure: ☐ No Limitation ☐ No exposure to (e.g. Heat, Cold, Noise, Scent, Chemical): _____ _____
Limited Use of Hands ☐ Not Applicable ☐ Gripping ☐ Pinching ☐ Other: _____ Please Specify : **Right Left Both**	Limited Pushing/Pulling with: ☐ Not Applicable ☐ Left Arm ☐ Right Arm Please specify weight and duration: _____ _____	☐ Potential side effects from medications related to this injury/illness. **(Please do not include names of medications)** _____ _____ _____

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.

PHYSICIAN'S NAME: (Please Print)_____

ADDRESS: _____

TELEPHONE: _____ FAX: _____

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

Once completed please return by <u>fax</u> 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**