



## **Application for Short Term Disability Leave (STD) – Package B**

(\*Please use this form if you are an ONA union employee and were employed by HHS BEFORE 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 – ONA Form B**

(\*Please use this form if you are an ONA union employee and were employed by HHS BEFORE 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 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 this injury/illness work related Yes No

Date first incapable of working: \_\_\_\_\_

Date first assessed to be totally disabled from all duties: \_\_\_\_\_

Specified period of absence: \_\_\_\_\_ (total disability)

Nature of illness or injury: \_\_\_\_\_ (no diagnosis)

Employee is under your active treatment: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prognosis/Return to work date: \_\_\_\_\_

Complete recovery expected: \_\_\_\_\_

## SECTION D

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

<input type="checkbox"/> Patient is capable of returning to work with no restrictions.	<input type="checkbox"/> Patient is capable of returning to work with restrictions. <b>Please complete full form.</b>	<input type="checkbox"/> Patient is physically unable to return to work at this time.  <b>Please complete full form with current abilities.</b>
--	--	---

Recommendation for working hours and start date:

<input type="checkbox"/> Full Hours	<input type="checkbox"/> Modified Hours <b>Please provide details in comments</b>	<input type="checkbox"/> Graduate Hours <b>Please provide Details in comments</b>	Start Date: _____ DD/MM/YYYY
-------------------------------------	--	--	------------------------------------

Please indicate **Abilities** that may apply:

<b>Walking:</b> <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 100 meters <input type="checkbox"/> 100-200 meters <input type="checkbox"/> Other ( <b>Please Specify</b> )	<b>Standing:</b> <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> Other ( <b>Please Specify</b> )	<b>Sitting</b> <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 30 minutes <input type="checkbox"/> 30 minutes – 1 hour <input type="checkbox"/> Other ( <b>please specify</b> )
<b>Lifting from floor to waist:</b> <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 5kg <input type="checkbox"/> 5-10kg <input type="checkbox"/> Other ( <b>please specify</b> )	<b>Lifting from waist to shoulder:</b> <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5kg <input type="checkbox"/> 5-10kg <input type="checkbox"/> Other ( <b>please specify</b> )	<b>Travel to Work:</b> <input type="checkbox"/> Ability to use public transit <input type="checkbox"/> Ability to drive car

Please indicate **Modifications** that apply:

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



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 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