



The University of Guelph has a self-funded sick leave program which provides income continuance for verifiable illness and injury for eligible employees. The University is committed to making every reasonable effort to assist ill or injured employees in their return to work. Please provide the following information to assist us in planning for your patient's safe return to work.

**Section A: Employee Information** (to be completed by employee)

|                                           |            |                             |                               |
|-------------------------------------------|------------|-----------------------------|-------------------------------|
| NAME: (Surname)                           |            | (Given Names)               | Date of Birth<br>(DD/MM/YYYY) |
| HOME ADDRESS: (Street, City, Postal Code) |            |                             | HOME/CONTACT PHONE NO.        |
| FACULTY/SCHOOL/SERVICE                    | DEPARTMENT |                             | JOB TITLE                     |
| MANAGER/SUPERVISOR NAME                   |            |                             | PHONE NO.                     |
| LAST DAY WORKED:                          |            | DATE OF FIRST MISSED SHIFT: |                               |

**Section B: Medical Information** (to be completed by a qualified medical practitioner).

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 short term disability/sick leave benefits.

General Nature of illness or injury: \_\_\_\_\_

Is the Employee under your direct, continuous and medically appropriate care? ☐ Yes ☐ No

Is the employee following a recommended treatment plan? ☐ Yes ☐ No

Estimated Return to Work Date: \_\_\_\_\_

Is complete recovery expected? ☐ Yes ☐ No

Do you believe this illness or injury is work related Yes No If yes, please complete a WSIB Form 8.

**Please indicate your patient's ability to return to work:**

☐ Employee unfit to work From: (DD/MM/YYYY) \_\_\_\_\_ To: (DD/MM/YYYY) \_\_\_\_\_

Please describe the impairment that is preventing this employee from performing any/all work:

Reassessment Date: (DD/MM/YYYY) \_\_\_\_\_

☐ Employee fit to return to full duties Effective Date (DD/MM/YYYY): \_\_\_\_\_

☐ Employee fit to return to modified duties (See Functional Capacity information).

Effective Date (DD/MM/YYYY): \_\_\_\_\_

☐ Employee fit to return to modified hours- Specify: \_\_\_\_\_

Duration: \_\_\_\_\_ Reassessment Date: \_\_\_\_\_

Name: \_\_\_\_\_ Department: \_\_\_\_\_

**The University of Guelph supports early and safe return to work. We are committed to fulfilling our accommodation obligations, providing modified duties, where available and appropriate, to support the recovery process. Please fully complete the following boxes as appropriate to identify your patient's capabilities / limitations.**

**Capabilities:**

|                           |                                         |                                         |                                        |                                                                         |
|---------------------------|-----------------------------------------|-----------------------------------------|----------------------------------------|-------------------------------------------------------------------------|
| Walking:                  | <input type="checkbox"/> full abilities | <input type="checkbox"/> Up to 100 mins | <input type="checkbox"/> 100-200m      | <input type="checkbox"/> other _____                                    |
| Standing:                 | <input type="checkbox"/> full abilities | <input type="checkbox"/> Up to 15 mins  | <input type="checkbox"/> 15-30 mins    | <input type="checkbox"/> other _____                                    |
| Sitting:                  | <input type="checkbox"/> full abilities | <input type="checkbox"/> Up to 30 mins  | <input type="checkbox"/> 30mins – 1 hr | <input type="checkbox"/> other _____                                    |
| Lifting floor to waist:   | <input type="checkbox"/> full abilities | <input type="checkbox"/> Up to 5 kgs    | <input type="checkbox"/> 5 – 10 kgs    | <input type="checkbox"/> other _____                                    |
| Lifting waist to shoulder | <input type="checkbox"/> full abilities | <input type="checkbox"/> Up to 5 kgs    | <input type="checkbox"/> 5 – 10kgs     | <input type="checkbox"/> other _____                                    |
| Stair climbing:           | <input type="checkbox"/> full abilities | <input type="checkbox"/> Up to 5 steps  | <input type="checkbox"/> 5 – 10 steps  | <input type="checkbox"/> own pace <input type="checkbox"/> as tolerated |
| Ladder climbing:          | <input type="checkbox"/> full abilities | <input type="checkbox"/> 1 – 3 steps    | <input type="checkbox"/> 4 – 6 steps   | <input type="checkbox"/> own pace <input type="checkbox"/> as tolerated |
| Hand use (R/L):           | <input type="checkbox"/> gripping       | <input type="checkbox"/> pinching       | <input type="checkbox"/> fine motor    | <input type="checkbox"/> other _____                                    |

**Limitations:** Please indicate restrictions that apply.

|                                                                                   |                                                              |                                                |                                                                                        |                                                |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Bending/twisting repetitive movement of (please specify) | <input type="checkbox"/> Work at or above shoulder activity: | <input type="checkbox"/> Chemical Exposure to: | <input type="checkbox"/> Environmental exposure to: (e.g. heat, cold, noise or scents) | <input type="checkbox"/> Kneeling or Squatting |
|-----------------------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------|----------------------------------------------------------------------------------------|------------------------------------------------|

|                                                                                                                                                                                      |                                                                         |                                                                                                                           |                                                                                                                             |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Limited pushing/pulling with:<br><input type="checkbox"/> Left Arm<br><input type="checkbox"/> Right Arm<br><input type="checkbox"/> Other (please specify) | <input type="checkbox"/> Operating motorized equipment: (e.g. forklift) | <input type="checkbox"/> Potential side effects from medications (please specify)<br>Do not include names of medications. | <input type="checkbox"/> Exposure to vibration:<br><input type="checkbox"/> Whole body<br><input type="checkbox"/> Hand/Arm |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------|

☐ Other

**Cognitive Functional Limitations (if applicable):** Please indicate the cognitive limitations and associated severity.

**Degree of Impairment**

|                                   | None                     | Mild                     | Moderate                 | Severe                   |
|-----------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Multi-tasking                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Memory                            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Attend to deadline pressures      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Critical decision making          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Working with others               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dealing with confrontation        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Dealing with emotional situations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Other _____                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

**By affixing my signature below, I certify that I am a qualified medical practitioner 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) \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ FAX: \_\_\_\_\_

DISCIPLINE/CREDENTIALS:

\_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE (DD/MM/YYYY): \_\_\_\_\_

Once completed please upload to our [OHW Secure Drive](#) or fax to Occupational Health and Wellness at (519) 780-1796.

**\*\*Any costs associated with providing the above information will be the responsibility of the employee.**