Appendix A

Ability Management Medical Form: Short Term Disability

Administrators (P/VP/System Lead/Other) | MPA

To: Healthcare Professional (Medical Doctor/Nurse Practitioner) and DDSB Staff Member,

To support the commitment of Human Rights, the DDSB has a Short-Term Disability (STD) and Return to Work Accommodation Programs for employees to access short term disability benefits due to illness or injury and/or to support return to work accommodations. The DDSB's Ability Management team works collaboratively with employees accessing STD benefits and/or who are returning to work and need workplace accommodation.

Information Required – Please Complete the Attached Medical Form:

1. A completed form is required at the **start** of the employee's absence to provide proof of illness or accommodation needs.
2. Please send the completed form to shortterm.absence@ddsb.ca or Fax 905-666-6953 or to designated Case Manager email.
3. If you have any question about when forms are required, please contact Ability Management.

Short Term Disability

To determine eligibility for STD benefits and to support the accommodation process and safe return to work, Ability Management requires medical information about the employee's physical and cognitive abilities, restrictions and/or limitations due to illness/injury/disability and any accommodation needs, via the attached medical form. The information you provide will help us assess STD eligibility and return to work and accommodation options and solutions.

- The DDSB does **not** require the employee's medical *diagnosis.* Employee's abilities are required.
- A standard medical sick note is generally **not** sufficient to determine eligibility for STD. **A completed form is required**.
- Regular update on medical form is required. The frequency of required updates will be assessed on an individualized basis.
    - Standard practice for longer leaves is regular updates every 3-4 weeks.
- A completed medical form is required at the end of the employee's absence to provide abilities to work.

Upon receipt of the completed medical forms (pages 2 and 3, attached), Ability Management case managers will:

- Review the identified abilities, limitations, restrictions, and needs against the existing physical and cognitive requirements/demands of the employee's job/position.
- Contact the employee if we require additional information or clarification to better understand the employee's needs/restrictions.
- Assess if based on the information provided, the employee can complete the essential duties of their role (with accommodation, where required).

Accommodation

DDSB meets its legal duty to accommodate and offers many forms of safe, individualized return to work accommodations (for example, modified hours of work, adjustments to the work duties, assistive or technological devices, placement in other positions more suited to current restrictions and limitations, etc.). The DDSB will:

- Adhere to the Ontario *Human Rights Code* and the DDSB's human rights and accommodation policies/procedures.
- Regularly review and monitor accommodations to determine if the accommodations continue to meet the employee's identified needs and restrictions. The DDSB may request updated medical forms/information if needs are unclear or have changed and may adjust the accommodations, as may be required.

Privacy and Confidentiality The information contained in this form is of a confidential nature and will be protected in a secure location within Ability Management Department. The information you provide will be treated confidentially and will only be shared on an as needed basis for as required by law, and in accordance with DDSB policies and procedures, to assess eligibility for STD benefits and potential return to work accommodation needs.

If you have any questions or concerns, please feel free to call the undersigned.

Sincerely,

Neil Maki
Manager, Ability Management, **People and Culture**, DDSB
neil.maki@ddsb.ca Telephone: **905-718-1164** Secured Fax: 905-666-6953

Ability Management Medical Form: Short Term Disability

Administrators (P/VP/System Lead/Other) | MPA

***To the Employee**: The form helps DDSB understand if you are able to perform your job duties and whether any medical restrictions require workplace accommodations, and the forms provide access to Short Term Disability Paid Benefits. I authorize my Healthcare Professional(s) to disclose medical information with my employer to help assess my ability to perform my job and support a safe and sustained return to work. I authorize them to respond to questions about this medical form, if required.*

Employee Name: (*Please print)*	**Employee Signature:**
Employee ID:	**Cell/Mobile No:**
Employee Personal Email Address:	**Work/School Location:**

***To the Healthcare Professional (Medical Doctor/Nurse Practitioner)**: DDSB has a Short-Term Disability/accommodation/return to work program and is committed to providing reasonable accommodations. Regular medical forms updates are required to support a safe and timely return to work or access to Short Term Disability Paid Benefits. Please provide clear and detailed medical information.

Healthcare Professional Name (please print):	**Date Completed:**
Signature:	**Clinic/Office Stamp:**

1. Healthcare Professional: The following information to be completed by Medical Doctor/Nurse Practitioner.

a. **Date of Assessment:** (dd / mm / yyyy)	b. **First Day of Absence:** (dd / mm / yyyy)
c. **General Nature of Illness***:	*Please provide a general statement of illness/injury without diagnosis details. "Nature of illness" and "diagnosis" are not congruent terms. For example, a cardiac condition or mental illness or abdominal surgery in that respect reveals the essence of the situation without revealing a diagnosis. Please do not use symptoms, such as stress, pain, or fatigue as this not a general nature category.

2. Healthcare Professional: Outline patient's abilities and/or restrictions based on objective medical findings/testing.

2A. PHYSICAL ABILITIES (Complete all limitations/restrictions in all categories with quantifiable information)

Walking:
- ☐ **FULL** Abilities
- ☐ Up to 200-400m or (15-30 min)
- ☐ Up to 100-200m or (10-15 min)
- ☐ Up to 100m or (5-10 min)
- ☐ Other (please quantify):

'

Standing:
- ☐ **FULL** Abilities
- ☐ 30 – 60 minutes at a time
- ☐ 15 - 30 minutes at a time
- ☐ Up to 15 minutes at a time
- ☐ Other (please quantify):

Sitting:
- ☐ **FULL** Abilities
- ☐ 30 minutes – 60 minutes
- ☐ 15 minutes – 30 minutes
- ☐ 5 minutes – 15 minutes
- ☐ Other (please quantify):

Stair Climbing:
- ☐ **FULL** Abilities
- ☐ 12 – 24 steps
- ☐ 6 - 12 steps
- ☐ up to 5 steps
- ☐ Other (please quantify):

Lifting from Floor to Waist:
- ☐ **FULL** Abilities
- ☐ Up to 15 kilograms (33 lbs.)
- ☐ Up to 10 kilograms (22 lbs.)
- ☐ Up to 5 kilograms (11 lbs.)
- ☐ Other (please quantify):

Lifting from Waist to Shoulder:
- ☐ **FULL** Abilities
- ☐ Up to 15 kilograms (33 lbs.)
- ☐ Up to 10 kilograms (22 lbs.)
- ☐ Up to 5 kilograms (11 lbs.)
- ☐ Other (please quantify):

Shoulder Activity
- ☐ **FULL** Abilities
- ☐ Limited **Left** ☐ Limited **Right**
- ☐ Able to work above shoulder with no repetition.
- ☐ Able to work below shoulder level.
- ☐ Limited shoulder movement (please quantify):

Waist/Low Back: Bending Twisting:
- ☐ **FULL** Abilities
- ☐ Able with some Repetition
- ☐ Able with no Repetition
- ☐ Limited in Bending/Twisting
- ☐ Other (please quantify):

Use of Left Hand:
- ☐ **FULL** Abilities
- ☐ Gripping Limited
- ☐ Pinching Limited
- ☐ Other (please quantify):

Use of Right Hand:
- ☐ **FULL** Abilities
- ☐ Gripping Limited
- ☐ Pinching Limited
- ☐ Other (please quantify):

Chemical/Environmental Exposure:
- ☐ Limited exposure to_____
- ☐ Referred to Specialist (provide 2nd page)
- ☐ Chemical/other name(s):
- ☐ Inhalation issue:
- ☐ Skin Contact issue:
- ☐ Other (please quantify):

Travel/Transportation
- ☐ **FULL** Abilities to **Drive Vehicle**
- ☐ Drive 30 - 60 minutes.
- ☐ Drive 15 - 30 minutes.
- ☐ Drive up to 30 minutes.
- ☐ Other (please quantify):
- ☐ **FULL** Abilities to use **Public Transit**
- ☐ Limited (please quantify):

2B. COGNITIVE Abilities (Complete all limitations/restrictions in all categories)

a) Ability to Work Independently:
- ☐ **FULL** Abilities (no supervision needed)
- ☐ Needs **Minor** supervision and/or direction.
- ☐ Needs **Occasional** supervision and/or direction.
- ☐ Needs **Frequent** supervision and/or direction.
- ☐ Needs **Constant** supervision and/or direction.

b) Supervision of Others:
- ☐ **FULL** Abilities
- ☐ Can manage staff/students with **Minor** Support from Supervisor.
- ☐ Can manage staff/students with **Occasional** Support from Supervisor.
- ☐ Can manage staff/students with **Frequent** support from management.
- ☐ Not able to supervise.

c) Responsibility & Accountability:
- ☐ **FULL** Abilities
- ☐ Can **accept a high level of responsibility** including sensitive situations.
- ☐ Can accept **responsibility for the** safety of others.
- ☐ Can exercise **a modest level of responsibility** with frequent support.
- ☐ **Errors in judgement or attention likely to occur.**

d) Performance on Multiple Tasks:
- ☐ **FULL** Abilities
- ☐ Can **handle multiple tasks**, requires **Minor** time management assistance.
- ☐ Can **handle multiple tasks**, requires **Occasional** time management assistance.
- ☐ Can handle **more than 1 task but Requires Cues** as to when to do a task.
- ☐ Can deal **with 1 task at a time**.

e) Tolerance to External Stimulus:
- ☐ **FULL** Abilities
- ☐ Can cope **with large degree of distraction with Small breaks required.**
- ☐ Can cope with **distracting stimulus for Portion of day**
- ☐ Can cope **with small degree of distraction with Large breaks required.**
- ☐ **Needs non distracting work environment for entire day.**

f) Tolerance to timeline/targets/deadlines:
- ☐ **FULL** Abilities
- ☐ Can deal with **strict timelines / targets.**
- ☐ Can deal with **recurring timelines / Targets pressures.**
- ☐ Can **occasionally deal** with **timelines / Targets pressures**.
- ☐ **Cannot deal** with timeline pressures.

g) Attention to Detail:
- ☐ **FULL** Abilities
- ☐ Can **concentrate intensely on detailed work**.
- ☐ Can concentrate on details, **needs breaks with non-detailed work.**
- ☐ **Concentration on detail is limited.**
- ☐ **Concentration on detail is Severely limited.**

h) Ability to cope with Confrontational Situations:
- ☐ **FULL** Abilities
- ☐ **Moderate ability to cope** with confrontational situations.
- ☐ **Can cope with exposure** to confrontational situations **with occasional support**.
- ☐ **Modest ability to cope** with confrontational situations **with frequent support**.
- ☐ **Unable to cope with any confrontational situations.**

3. Healthcare Professional: Outline patient's next steps, Return to work, treatment path, based on objective medical findings.

Date of Next Medical Assessment:
(dd / mm / yyyy):

From the date of this assessment, **the above will apply** for:
☐ 1-2 days ☐ 3-7 days ☐ 8-14 days ☐ 15+ days

Is your patient participating in ACTIVE TREATMENT plan?
☐ Yes ☐ No
If Yes, what kind of treatment:

Has a referral been made to a Specialist?
☐ Yes ☐ No
☐ Specialist Name:
☐ Assessment/potential date:

If a referral has been made, in the meantime, will you continue as the patient's primary Healthcare Professional?
☐ Yes ☐ No

Have you discussed return to work with your patient?
☐ Yes ☐ No

Return to Work Start Date: (dd / mm / yyyy)

If delayed, please provide medical rationale for delay:

Recommendations for work hours: ☐ Regular **Full**-time hours/days ☐ Modified days/hours ☐ Graduated days/hours

Additional Information: Findings, Comments, Abilities, Limitations, Restrictions with Medical Rationale to support information provided: