



## ATTENDING PRACTITIONER'S STATEMENT REPORT

### SECTION 1: To be completed by the employee

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Civic  General  
 Riverside

I hereby authorize \_\_\_\_\_ my attending practitioner who has provided care to me during my absence from work for the dates (from) \_\_\_\_\_ (to) \_\_\_\_\_ to release the medical information requested in the following questionnaire to Occupational Health Safety and Emergency Preparedness to explain my absence(s) in order to facilitate my return to work.

**Employee signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

*The Ottawa Hospital offers an Employee Assistance Program as well as an Early and Safe Return to Work Program to assist the reintegration of employees at work who are ill or have been injured. Hence, the information provided will be of assistance to ensure that employees are given the opportunity to return to work as soon as possible. We appreciate your prompt completion of this form*

### SECTION 2: To be completed by the attending practitioner

General Medical Information:

1. Is the employee taking medication which will impair his/her judgement or ability to operate equipment safely at work?  Yes  No
2. Is the employee receiving treatment from a specialist?  Yes  No  being referred
3. Is the employee following the treatment plan:  Yes  No  N/A
4. What are the components of the treatment plan?  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

5. How frequent are the employee's appointments \_\_\_\_\_
6. How long do you expect the condition to last? \_\_\_\_\_
7. What limitations does the condition place on work life activities?  
 \_\_\_\_\_  
 \_\_\_\_\_

### PROGNOSIS FOR SAFE RETURN TO WORK

Based on your assessment, the employee:

- Can return to work to modified duties/hours? Duration: from \_\_\_\_\_ to \_\_\_\_\_  
 Please provide details about the return to work plan, including restrictions if applicable, and hours of work:  
 \_\_\_\_\_  
 \_\_\_\_\_

- Can return to regular duties and if so, indicate when: \_\_\_\_\_

- Is unable to return to work  Expected date of return to work: \_\_\_\_\_

Please provide any other comment that would assist us in ensuring proper accommodation/ safe return to work.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- May our Occupational Health Nurse/Physician contact you to discuss the above information?**  Yes  No

Attending Practitioner information (please print)

Surname	Given name	Specialty
Address (Street, Apt, City)	Postal Code	Telephone
		Email address
		Fax
Signature		Date

**Please note** that this form must be completed and returned to the Occupational Health Safety and Emergency Preparedness (OHSEP) promptly following employee's visit or their sick leave benefits may be affected. The Hospital will pay a maximum of \$50.00 for this report. Please return the form to the OHSEP of the campus where your patient works. If required, call the OHSEP at the specific campus.

<p>OHS 30 (09/2010)</p> <p><b>OHSEP</b></p>	<p><b>Civic Campus</b>                  1053 Carling Avenue                  Ottawa, Ontario K1Y 4E9                  Fax.: 761-4162,                  Tel.: 798-5555-14161</p>	<p><b>General Campus</b>                  501 Smyth Road                  Ottawa, Ontario K1H 8L6                  Fax.: 737-8912,                  Tel.: 737-8899-78391</p>	<p><b>Riverside Campus</b>                  1967 Riverside Drive                  Ottawa, Ontario K1H 7W9                  Fax.: 738-8260,                  Tel.: 738-8400-88250</p>
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