



Health Progress Report Physician Statement

Dear Physician:

Your patient is requesting accommodation or absence from their position. Please complete and fax to Occupational Health Nurse's confidential fax line 905-721-4238. Potentially Health Progress Reports may be requested for an update on a bi-weekly basis.

The Durham Regional Police Service (DRPS), offers accommodated duties to all injured or ill members. If your patient is totally disabled and unable to participate in accommodated duties, please be prepared to substantiate your patient's absence with objective medical so they will not be subjected to a loss in pay.

Thank you for providing the required medical information that will assist us in facilitating our employee's timely return to work. If all sections are legibly completed, DRPS will reimburse \$40.00 for this form. Mail invoice to: Durham Regional Police Service, Health, Wellness and Safety Unit, 605 Rossland Road East, PO Box 911, Whitby, ON, L1N 0B8.

PART A: To be completed by DRPS member

Non-occupational Long term disability WSIB - claim #: _____

Surname	Given one	Reg. #	
Rank and / or job title	Work location		
Street address	City / town	Province	Postal code
Nature of injury / illness		Date of onset (YYYY-MM-DD)	

Member consent

I, _____ hereby authorize and direct any regulated medical practitioner providing treatment to me to disclose the following information about my medical condition and related treatment to the Occupational Health Nurse for the purpose of:

- (a) determining the validity of an absence;
- (b) determining eligibility for benefits, including those under the current Collective Agreement;
- (c) developing accommodation plans and proposals;
- (d) ensuring safe returns to work; and
- (e) for attendance management purposes.

The information authorized to be disclosed is information pertaining to my work capabilities, accommodation requirements and / or functional abilities related to the medical condition for which I am seeking treatment. I further authorize the occupational health nurse to release this information to the Workplace Safety and Insurance Board (WSIB) and / or Great West Life if required.

I acknowledge and agree that a reproduction of this signed consent is, and shall be, as valid as an original.

Dated at _____, Ontario this _____ day of _____, 20 ____

Member's name (please print)

Member's signature

EACH OF THE FOLLOWING SECTIONS TO BE COMPLETED BY HEALTH PROFESSIONAL (please print)
 If included, please review attached Physical Demands Analysis / Job Description for the position.

Health practitioner (please print)	Field of practice (medicine, physio, chiropractor)	Signature	
Address		City	
Telephone	Fax #	Postal code	

Date this form is completed: _____
 YYYY-MM-DD

1. Is the employee capable of returning immediately to regular duties without restrictions? Yes No

2. If 'Yes', no further information is required. If 'No', health professional should complete each of the following sections.

3. Nature of illness / injury (please complete)

4. If you consider that your patient is unfit to do any work (i.e., unfit to work, totally disabled, meaning hospitalized or otherwise incapable of performing acts of daily living), please state reasons why this employee cannot return to accommodated duties, as per the Ontario Medical Association's (OMA), **Guidelines for Timely Return to Work** and legislative requirements for accommodations (please attach any additional pages you may have).

5. Is this a recurring issue? Yes No

6. If 'Yes' please provide date: _____
 YYYY-MM-DD

7. Explanation:

8. Date of onset of present episode: _____

9. Physical restrictions (that correspond to the illness / injury): None Yes If 'Yes' - Provide specific details (e.g., weights / frequency)

Walking	<input type="checkbox"/>	<input type="checkbox"/>	Maximum distance: _____
Standing	<input type="checkbox"/>	<input type="checkbox"/>	How long? _____
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	How long? _____
Crouching / kneeling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lifting floor to waist	<input type="checkbox"/>	<input type="checkbox"/>	Maximum lbs. / kgs. _____
Lifting waist to shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Maximum lbs. / kgs. _____
Lifting above the shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Maximum lbs. / kgs. _____

continued from page 2:

	None	Yes	If 'Yes' - Provide specific details (e.g., weights / frequency)
Ability to use hands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ability to use arms	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gripping	<input type="checkbox"/>	<input type="checkbox"/>	_____
Operating motorized equipment / car	<input type="checkbox"/>	<input type="checkbox"/>	_____
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	Maximum lbs. / kgs. _____
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	Maximum lbs. / kgs. _____
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	Maximum steps / stairs _____
Bending / twisting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Medication related	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____

10. Complete only for non-physical disabilities (that correspond to the illness / injury):

Requires supervision	<input type="checkbox"/> No	<input type="checkbox"/> Occasionally	<input type="checkbox"/> Always
Performs supervision	<input type="checkbox"/> Not able	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No restrictions
Meets deadlines	<input type="checkbox"/> Not able	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No restrictions
Pays attention to detail	<input type="checkbox"/> Not able	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No restrictions
Ability to multi-task	<input type="checkbox"/> Not able	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No restrictions
Works with distractions	<input type="checkbox"/> Not able	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No restrictions
Works with others	<input type="checkbox"/> Not able	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No restrictions
Works in emotional situations	<input type="checkbox"/> Not able	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No restrictions
Handles behavioural situations	<input type="checkbox"/> Not able	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No restrictions
Makes decisions	<input type="checkbox"/> Not able	<input type="checkbox"/> Occasionally	<input type="checkbox"/> No restrictions
Communicates	<input type="checkbox"/> Not able	<input type="checkbox"/> Basic	<input type="checkbox"/> Fluent
Memory	<input type="checkbox"/> Short term only	<input type="checkbox"/> Long term only	<input type="checkbox"/> No restrictions
Ability to read	<input type="checkbox"/> Point form	<input type="checkbox"/> Instructions	<input type="checkbox"/> No restrictions
Ability to write	<input type="checkbox"/> Point form	<input type="checkbox"/> Reports / letters	<input type="checkbox"/> No restrictions
Numerical skills	<input type="checkbox"/> Able to count	<input type="checkbox"/> Simple math	<input type="checkbox"/> No restrictions
Copying	<input type="checkbox"/> Not able	<input type="checkbox"/> Transfers info.	<input type="checkbox"/> No restrictions
Computer work	<input type="checkbox"/> Not able	<input type="checkbox"/> Basic use	<input type="checkbox"/> No restrictions
Other (please print)	_____		

11. Provide details of current active treatment plan including all referrals and describe response to current treatment plan:

12. Expected duration of restrictions: _____

Provide explanation: _____

13. Is your patient following the recommended treatment program? Yes No

If 'No' please describe why. _____

14. Complete recovery expected?

Yes Date: _____

No Provide explanation: _____

Unknown Provide explanation: _____

15. Hours of work that employee is capable of working:

Normal / usual hours Date: _____

Accommodated hours:

of hours / day: _____ # of hours / week: _____ # of days / week: _____

Graduated hours:

Week #1: _____ Week #2: _____ Week #3: _____ Week #4: _____

16. Date of reassessment: _____

Additional comments: