**Policy & Procedure Manual**

# MEDICAL DOCUMENTATION – HR-IX-3

## POLICY:

Current medical documentation from a recognized health care practitioner is required by all employees when off work for a period of three or more days due to a non-occupational illness or injury and documentation may be required at any time where an employee is having difficulties performing job duties and/or meeting their obligations of employment. (For work-related illness/injury see Policy HR-XI-22) medical documentation must be to OPTIONS NORTHWEST satisfaction.

## PURPOSE:

1. To assist the employee in obtaining any required assistance.

2. To confirm ability to perform essential job duties and work scheduled hours.

3. To assist both employer and employee in assessing reasonable accommodation, under the Human Rights Code and the integrated accessibility standards under the Accessibility for Ontarians with Disability Act.

4. To qualify for sick leave, whether paid or unpaid.

5. To assist the employer's ability to plan, i.e. for shift coverage, assess accommodation.

## PROCEDURE:

Medical documentation may be requested at any time and whenever such documentation is requested for absence from work due to illness or injury or disability it is expected that employees provide such medical documentation for medical attention sought at the time of the absence/illness. Appropriate documentation as indicated, is required to determine eligibility for sick leave, any available pay associated with sick leave, and to assess such information to determine reasonable accommodation, as appropriate.

1. The employee who calls in ill for work shall dialogue with his/her Supervisor/ Manager/Director regarding their absence and confirm any requirement for medical documentation.
   NOTE: Contact via text to report absence from work is unacceptable.

2. a) Generally, for absences of 3 to 6 days, medical documentation must outline that the employee is under the care of a qualified practitioner and state their level of fitness for a return to work for the position occupied.

   b) For absences greater than 6 days, medical documentation must outline the following:
      i. that the employee is under the ongoing care of a qualified practitioner,
      ii. the anticipated length of time required for recovery,
      iii. the plan of action for treatment/care,
      iv. workplace restrictions, limitations or precautions

   An Employee Medical/Work Limitation Form, as may be appropriate, may be asked to be completed by the medical practitioner and returned to the Coordinator Health and Safety/Designate or Manager, Human Resources. (See Appendix A.)

   NOTE: Further medical documentation may be requested at any time depending on individual circumstances.

3. Where detailed medical documentation is required, the Coordinator Health and Safety/Designate shall ensure the employee is given a "Consent for Release of Medical Information" (Appendix B) to sign prior to OPTIONS NORTHWEST requesting such documentation from a medical practitioner.

4. The Supervisor/Manager/Director shall forward any medical documentation received from the employee to the Coordinator Health & Safety/Designate or Manager, Human Resources for review and placement of originals or verified originals in the employee's health file. No copies of medical correspondence are to be retained by the Supervisor/Manager/Director.

5. The policy shall apply equally to all employees of OPTIONS NORTHWEST. Failure of any employee to produce appropriate medical documentation in the manner requested may:
   - restrict an employee's ability to return to work
   - restrict approval of sick leave, paid or unpaid
   - constitute grounds for disciplinary action.

6. When disability is confirmed through medical documentation the employer will assess any restrictions identified for workplace accommodation, shall follow procedures under Policy HR-XI-27 Workplace Accommodation Policy in accordance with Human Rights legislation.

7. For employees who have been absent due to disability, a return to work meeting may be facilitated with the employee. The purpose of the meeting is to develop a return to work plan that attempts to reasonably accommodate identified restrictions/abilities, allows for input and the best chance for a successful return to the essential job duties.

**RECOMMENDED BY:** Manager, Human Resources **APPENDICES:** 2

**OPERATIONAL ACCOUNTABILITY:** Administration, Finance, Human Resources, Supportive Living Services (all)

**ORIGINAL POLICY DATE:** January 1993

**AUTHORIZED BY:** Executive Director

**SIGNATURE:** 

POLICY: HR-IX-3
APPENDIX A

OPTIONS NORTHWEST

# CONSENT FOR RELEASE OF MEDICAL INFORMATION

I, _____, hereby authorize the release of information
Name and Date of Birth
as requested/required below:

1. I give my permission to OPTIONS NORTHWEST to contact _____ to assist in
Name of Practitioner
the evaluation of my ability to perform my work. This information shall only be released to the Health & Safety Coordinator or his/her designate.

2. I give permission to _____ to release to the Health & Safety Coordinator
Name of Practitioner
or designate such information that is relevant to my physical, emotional and/or psychological ability to perform my work.

3. I give permission to the Health & Safety Coordinator or designate to release, to appropriate or specified Management, any information that she/he determines is relevant to my ability to work.

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It is understood that this information is of a confidential nature and all parties must respect this confidentiality. It is also understood that I may be provided with any information released should I request the same.

_____ _____
Employee Signature Witness Signature

_____ _____
Date Date

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Appendix B

# Worker Capabilities Form

To be used for return-to-work planning following personal injury/illness

OPTIONS NORTHWEST
*live life your way*

**Health Professionals Designation:** ☐ **Physician** ☐ **Physiotherapist** ☐ **Nurse Practitioner** ☐ **Other** _____

Employee Name: _____ Phone Number: _____

Job Title: _____ Assessment Date: _____

Area of Injury/Type of Injury/Illness: _____

**EMPLOYEE AUTHORIZATION [To be completed by Employee]**

I authorize the release of the following information to OPTIONS NORTHWEST.

Signature: _____

☐ Worker is capable of returning to work with **no restrictions**

☐ Worker is capable of returning to work **with restrictions** (complete rest of form)

☐ Worker is physically unable to return to work at this time.

Rehabilitation/Treatment Required: ☐ YES ☐ NO

****All employees are trained in First Aid/CPR & NCI ****
Can the employee perform First Aid/CPR & NCI ☐ YES ☐ NO

| **Please indicate ABILITIES that apply (additional space available under 'Additional comments')** | | | |
|---|---|---|---|
| **Walking:**<br>☐ Full abilities<br>☐ Up to 100 metres<br>☐ 100 – 200 metres<br>☐ Other (please specify) | **Standing:**<br>☐ Full abilities<br>☐ Up to 15 minutes<br>☐ 15 – 30 minutes<br>☐ Other (please specify) | **Sitting:**<br>☐ Full abilities<br>☐ Up to 30 minutes<br>☐ 30 minutes – 1 hour<br>☐ Other (please specify) | **Lifting from floor to waist:**<br>☐ Full abilities<br>☐ Up to 5 kilograms<br>☐ 5 – 10 kilograms<br>☐ Other (please specify) |
| **Lifting from waist to shoulder:**<br>☐ Full abilities<br>☐ Up to 5 kilograms<br>☐ 5 – 10 kilograms<br>☐ Other (please specify) | **Stair climbing:**<br>☐ Full abilities<br>☐ Up to 5 steps<br>☐ 5 – 10 steps<br>☐ Other (please specify) | **Ladder climbing:**<br>☐ Full abilities<br>☐ 1 – 3 steps<br>☐ 4 – 6 steps<br>☐ Other (please specify) | **Travel to work:**<br>Ability to drive a car:<br>☐ YES ☐ NO<br>Ability to use public transit:<br>☐ YES ☐ NO |

| **Please indicate PHYSICAL RESTRICTIONS that apply** | | | | |
|---|---|---|---|---|
| ☐ Bending/twisting or repetitive movement of<br>_____<br>(please specify) | ☐ Work at or above shoulder activity | ☐ Chemical exposure to: | ☐ Environmental exposure to: | ☐ Exposure to vibration:<br>☐ Whole body<br>☐ Hand/Arm |
| ☐ Limited pushing/pulling with:<br>☐ Left arm<br>☐ Right arm<br>☐ Other:<br>_____ | ☐ Limited use of hand(s):<br>Left / Right<br>☐ Gripping ☐<br>☐ Pinching ☐<br>☐ Other _____ ☐ | ☐ Potential side effects from medications (please specify)<br>_____ | ☐ Work in a highly stressful environment. | |

**HS050/MAY2022**

| Please indicate COGNITIVE/ MENTAL RESTRICTIONS that apply | | | |
|---|---|---|---|
| ☐ Difficulty in following a schedule, maintaining attendance/punctuality | ☐ Difficulty in shift work, rotating schedules | ☐ Difficulty in meeting deadlines (frequently or occasionally) | ☐ Difficulty in Maintaining stamina/pace of work<br>☐ Monotomy |
| ☐ Difficulty in handling prolonged work days, over time | ☐ Difficulty working in isolation | ☐ Difficulty in relationship building/networking<br>☐ Difficulty with influencing others | ☐ Problem solving/decision making<br>☐ Organizational ability/time management |
| ☐ Difficulty in conflict resolution (negotiating, mediating) | ☐ Difficulty in working with crisis or emergency situations<br>☐ Self-supervision/autonomy | ☐ Difficulty with teamwork<br>☐ Multitasking | ☐ Difficulty in seeking/responding to feedback/constructive criticism |
| ☐ Exposure to emotional or confrontational situations | ☐ Working closely with the public, clients or others in face to face settings | ☐ Attention to Detail<br>☐ Adaptability | ☐ Working under specific instructions<br>☐ Sound judgement |

**Additional comments on ABILITIES and/or RESTRICTIONS. Required for any RESTRICTIONS noted.**

| Recommendation for hours of work: | Complete recovery expected? | Estimated duration of limitations: |
|---|---|---|
| ☐ Regular Hours ☐ Modified Hours<br>☐ Graduated Hours<br>*Have you discussed return to work with your patient<br>☐ Yes ☐ No | ☐ YES ☐ NO | ☐ 1 – 2 days ☐ 3 – 7 days<br>☐ 8 – 14 days ☐ 14 + days<br>Date of next appointment: |
| Health Professional's Name: (please print) | Health Profession: | Signature: |

**Please return the completed form to the Human Resources Department following your appointment.**