1992 Attending Practitioners Statement (APS)

QUICK REFERENCE SHEET

Attention:

- This form is to used by all staff (including ONA), except ONA employees hired before January 1, 2006

This quick reference page has been developed to ensure that there is no delay or concerns surrounding the completion of the Attending Practitioner's Statement (APS).

Every employee who is **absent from the workplace due to their illness or injury of ten or more consecutive shifts must have the attached applicable APS fully completed.**

Before leaving your medical practitioner's office / clinic please ensure:

- **Section A** – to be completed by the Employee
- **Sections B, C & D** – to be completed by the Attending Practitioner
  - Note direction in the box *"... all information requested must be fully completed..."* (this section is not to be completed by employees, or the office nurse)
  - Nature of illness or injury – i.e. respiratory, musculoskeletal, mental health, etc. (a response of "medical condition or medical illness" is not acceptable)
  - Employee is under active treatment (please identify): medication, physiotherapy, counseling, chiropractor, etc. (a response of "medical treatment", or leaving the area blank is not acceptable)
- The APS is signed by the Attending Practitioner. **A stamp only is not satisfactory**
- The completed APS is submitted to Ability Management within 7 days of the 10th consecutive missed shift
- The completed and submitted **APS is the only medical form accepted**; other forms (i.e. script notes, etc.) are not acceptable

If you have any questions regarding the Attending Practitioner's Statement, please contact Ability Management at: abilitymanagement@sah.on.ca

Dear Attending Health Care Practitioner:

Sault Area Hospital (SAH) offers a comprehensive sick leave program, temporary transitional modified duties and/or accommodation, if necessary, to assist and support our employees who become ill and/or injured. To assist SAH in applying such supports, the attached Attending Practitioner Statement (APS) is required. We rely on the timely receipt of medical documentation that outlines our employee's functional abilities, therefore please complete APS in the next 7 days from receipt.

As the treating practitioner, your completion of all sections of this form is required to substantiate our employee's sick leave (which may include sick pay benefits) and/or to support the need for Gradual Return to Work (GRTW) or accommodation, based on functional abilities, and as medically appropriate.

It has been shown that early intervention and return to the workplace may reduce overall recovery times and limit the negative impact of a prolonged absence. As such, temporary GRTW plans can be provided to employees to support and ensure a successful return to full regular duties. GRTW must be goal oriented, time limited (typically four to six weeks in duration), progressive in nature and based on medically supported functional abilities.

If fees are associated with the request for medical information, please note that the Hospital will provide reimbursement based on what is deemed reasonable and customary, up to a maximum $80. The preferred approach is for the employee to pay, obtain a receipt and submit to the Hospital for reimbursement. Alternatively, you can submit an invoice along with the completed information, in which case, SAH will reimburse you directly.

We thank you for your support and care of our employee, and appreciate your time, assistance, and cooperation in responding to this request.

If you have any questions or concerns, please feel free to contact us directly.

Kind Regards,

Ability Management
Sault Area Hospital

HOODIP 1992 – Attending Practitioner's Statement

(This form is to used by all staff (including ONA), except ONA employees hired before January 1, 2006)

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

Last, First Name: _____ Job Title: _____

Phone: _____ Last Day Worked**:** _____

First Missed Shift: _____ Manager / Supervisor: _____

Preferred E-mail Address Work or Personal (optional): _____

*I authorize the attending practitioner to disclose information to Sault Area Hospital - Ability Management Team regarding my medical condition(s) as it relates to my **current** absence from work for the purposes of validating and managing my claim for a medical leave of absence, coordinating safe and timely return to work and/or modified duties, and/or the need for any medical accommodations in my workplace. I understand that I will be informed when any information or request needs to be made to my practitioner.*

Employee Signature: _____ Date : _____

Section B: Attending Practitioner Statement (to be fully completed by Attending Practitioner)

*Dear Attending 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 appropriate benefits. Sault Area Hospital supports safe and timely return to work as part of the recovery process, and is committed to providing modified duties for employees who are not totally disabled.*

Date first incapable of working: _____ Dates subsequently examined: _____

Date first assessed to be totally disabled from all essential duties: _____

Specified period of absence due to total disability: _____

Nature of Illness/Injury (i.e. a general statement of a person's illness/injury, not diagnosis) :

_____

☐ A communicable disease potentially reportable to Public Health ☐ MVA ☐ Workplace Injury (WSIB)

☐ A surgical matter: ☐ Yes ☐ No

*If yes, and if an "elective" surgery, is this procedure covered under OHIP: ☐ Yes ☐ No

☐ hospitalization from (dd/mm/yy) _____ to (dd/mm/yy) _____

Is employee under active and continuous treatment(s), for which are appropriate and that you have prescribed?

☐ Yes ☐ No

Please describe treatment plan: _____

Is employee being compliant with treatment plan? _____

At this time, what is the prognosis for a complete recovery? ☐ Poor ☐ Guarded ☐ Good

Section C: Recommended Functional Capabilities: (to be completed by Attending Practitioner)

	CAPABILITIES	LIMITATIONS
Physical	Walking: ☐ Short distances only ☐ long distance	☐ Bending or Twisting of:
	Standing: ☐ less than 15 minutes ☐ more than 30 minutes	☐ Above shoulder activity:
	Sitting: ☐ less than 30 minutes ☐ less than 1 hour	☐ Below shoulder activity :
	Lifting floor to waist: ☐ less than 10lbs ☐ less than 25lbs	☐ Restrictions related to medication (specify):
	Lifting waist to shoulder: ☐ less than 10lbs ☐ less than 25lbs	☐ Repetitive movement of:
	Above shoulder activity: ☐ less than 10lbs ☐ less than 25lbs	
	Push / Pull: ☐ less than 5lbs ☐ less than 10lbs	
	Limited ability to use hand to: ☐ hold objects ☐ grip ☐ type ☐ write	

Cognitive	**Level of Ability**	**Unable**	**Minimize**	**Moderate**	**High**
	Perform repetitive or short cycle work				
	Perform at a constant pace				
	Maintain attention and concentration				
	Understand, remember and carry out complex job instructions				
	Use a judgement and make decisions				
	Direct, lead or plan activities of others				
	Work alone or apart in physical isolation from others				
	Recommendation for Work hours: ☐ Full Time Hours ☐ Graduated Hours				
	If graduated hours, please provide proposed plan with duration, along with rationale:				
	Additional Comments to the Above:				
	Next Reassessment Date:				

Section D: Attending Practitioner's Authorization: (to be completed by Attending Practitioner)

By affixing my signature below, I certify that I am a qualified attending practitioner and that I have personally assessed and treated the above patient/employee. It is my opinion that the information contained within this form is true, accurate and represents information found within my treatment/medical notes.

Name of attending practitioner (please print): _____

Phone: _____ Fax: _____

Attending practitioner signature: _____ Date: _____ _____

Practitioner's Stamp

Once completed, please return this form via FAX or EMAIL to the Sault Area Hospital Ability Management Fax: 705-256-4711 or Email: abilitymanagement@sah.on.ca