Trillium Health Partners
Better Together

Attending Practitioner Report (APR) | People Safety & Support

All sections of this form must be completed in full in order to be processed

Is this a work-related illness/injury? ☐ **Yes** ☐ **No**

If yes, do not complete this form. Please have your attending practitioner complete a WSIB Form 8.

CONFIDENTIAL

Section A: Employee Information (to be completed by the Employee)

THP is committed to protecting your privacy. The personal information in this form is collected in accordance with the Freedom of Information and Protection of Privacy Act ("FIPPA"). It will be used and maintained in the strictest confidence by THP for the intended purpose of supporting a sick leave, accommodation, and/or return to work information. If you have any questions about the collection, use and disclosure of the personal information provided on this form, please contact People Safety at PeopleSafety@thp.ca

Employee Full Name:	_____	Date of Birth:	_____
Personal E-mail:	_____	Employee ID:	_____
Department:	_____	Employee Phone:	_____
Position:	_____	Manager/Supervisor:	_____

Date of First Shift Absent: _____ Status: FT PT CAS

I hereby authorize the practitioner, who, by completing and signing this form, may release medical or functional information pertaining to my current medical absence to People Safety & Support and allow them to determine sick leave benefits and/or provide return to work information to my Manager/ Supervisor to facilitate a safe return to work.

Employee Signature: _____ Date (mm/dd/yy): _____

Section B: Medical Assessment (to be completed by the Practitioner)

In accordance with the Ontario Medical Association (OMA) position paper, which supports the timely return to work programs and the role of the primary care physician, please provide objective reports on impairment, prognosis, treatment, medical restrictions and/or limitations, and other supporting documentation. Please note that we are not asking for a diagnosis.

1. **Nature of Illness/Injury** (we require this information for the purpose of adjudicating sick benefits): Please describe the illness/injury and the functional impairment that is preventing the employee from performing their essential duties.

   _____

   _____

   If the patient has a secondary medical condition that may prolong the length of absence, please explain: _____

2. **Absence Information:**
   i. Date illness/injury began: _____
   ii. Date of first visit for current illness/injury: _____
   iii. Date of planned follow-up: _____
   iv. Planned frequency of follow-up visits: _____
   v. Is absence due to a chronic illness/injury? ☐ Yes ☐ No

Absence Information (continued):

Motor Vehicle Accident: ☐ Yes ☐ No

Surgery or Procedure as treatment? If yes, date of surgery (mm/dd/yy): _____
If yes, is it covered by OHIP? ☐ Yes ☐ No

Hospitalized? If yes, from: _____ to _____

Pregnancy related? If yes, please confirm estimated date of confinement (EDC): _____

3. **Is there an active treatment plan currently in place?** ☐ Yes ☐ No

   If yes, is the patient compliant with the treatment plan? ☐ Yes ☐ No

4. **Is the patient presently under the care of a medical specialist?** ☐ Yes ☐ No
   If no, has a referral occurred? ☐ Yes ☐ No ☐ N/A

5. **By signing below, I verify that, based on my assessment and objective medical evidence, the patient is totally disabled** (unable to perform *the essential job duties or hours*) from (date): _____ with an expected return to:
   Modified duties on (date): _____ or
   Regular duties (no restrictions) on (date): _____
   Are there any restrictions to maximum hours of work per day/shift?
   ☐ 4 hours ☐ 8 hours ☐ 12 hours ☐ No restrictions

THP offers modified work or hours for employees who are able to work but may not be able to perform their full duties. It is the Hospital's expectation that, where capable, employees will return to work to perform their essential duties on a modified basis or other duties if available.

Section C: Recommended Physical Abilities (to be completed by the Practitioner)

1. Please indicate patient's current functional abilities as of today's assessment, regardless of return to work status. Check all that apply.

Walking	☐ 0 – 15 min		☐ 15 – 30 min		☐ 30 – 60 min		
Sitting	☐ 0 – 15 min		☐ 15 – 30 min		☐ 30 – 60 min		
Standing	☐ 0 – 15 min		☐ 15 – 30 min		☐ 30 – 60 min		
Stair Climbing	☐ Full Abilities		☐ Limited Abilities		☐ Cannot Perform		
Ladder Climbing	☐ Full Abilities		☐ Limited Abilities		☐ Cannot Perform		
Bending	☐ Full Abilities		☐ Limited Abilities		☐ Cannot Perform		
Crouching/Kneeling	☐ Full Abilities		☐ Limited Abilities		☐ Cannot Perform		
Repetitive Motion	☐ Full Abilities		☐ Limited Abilities		☐ Cannot Perform		
Pushing/Pulling	☐ Sed. (0 – 10 lb)		☐ Light (11 – 20 lb)		☐ Med. (21 – 50 lb)		
Lifting/Lowering	☐ Sed. (0 – 10 lb)		☐ Light (11 – 20 lb)		☐ Med. (21 – 50 lb)		
Carrying	☐ Both Hands	☐ Left Hand	☐ Right Hand	☐ Limited	Max. Weight (lb):		
Fine Finger	☐ Both Hands	☐ Left Hand	☐ Right Hand	☐ Limited			
Gripping/Grasping	☐ Both Hands	☐ Left Hand	☐ Right Hand	☐ Limited	Max. Weight (lb):		

2. **Please add any other functional abilities not listed above:**

   _____

   _____

3. **Cognitive Capabilities – Please indicate any limitations. Please indicate PHQ-9 or GAD-7 score, if relevant:**

   _____

   _____

Section D: Attending Practitioner Contact Information & Fees

Fees for Completion of Medical Certificate: It is the responsibility of the patient/employee to pay for completion of the form and submit the original receipt for reimbursement. Fees will be reimbursed in accordance with OMA guidelines, THP's policy, and union collective agreement.

I have personally assessed and treated the above patient/employee. To my knowledge, the above information is true and accurate.

Practitioner's Name:_____ **Professional Designation/Specialty (e.g., MD, NP, Specialist):** _____ **CPSO#/License #/Registration #:** _____ **Phone:** _____ **Fax:**_____ **Signature:** _____ **Date:** _____	Practitioner's Stamp

PLEASE RETURN COMPLETED FORM WITHIN **5 BUSINESS DAYS** TO PEOPLE SAFETY & SUPPORT by **FAX: 416-521-4160 or E-MAIL: employeemedical@thp.ca**