Sinai Health | Mount Sinai Hospital
Joseph & Wolf Lebovic Health Complex

Occupational Health and Safety
60 Murray St., Box #1, Rm. L1-028
Toronto, ON M5T 3L9
T 416-586-4800 ext. 1572
F 416-361-2663
ohsmsh@sinaihealth.ca

Treating Physician / Practitioner Statement

(To be completed by all employees including ONA members hired after January 1, 2006)

Section A: Employee Information (To be completed by the employee)

Name: ______________________ Dept: ________________ Job Title: ____________

Address: ______________________ City: ________________ Postal Code: ____________

Phone: H ____________ W ____________ Supervisor / Manager: ____________________

Union: ☐ CUPE ☐ ONA ☐ OPSEU ☐ NOWU ☐ None

First Day of Absence: ______________________

Section B: Employee Consent (To be completed by the employee)

I hereby authorize my physician to release the information on this form to Occupational Health and Safety (OHS) at Mount Sinai Hospital. OHS may contact my physician to clarify the information on this form but my physician is not to provide additional information, and OHS is not to request additional information, unless or until I sign a second consent. **I understand that I may revoke this authorization at any time.**

Employee Signature: ________________________________ Date: ________________

All medical information received will be kept in strict confidence in the employee's medical file.

Section C: Illness/Injury Information (To be completed by physician/practitioner)

Type of Disability:

☐ Illness/Injury ☐ MVA ☐ Optional Medical Procedure Not Covered by OHIP ☐ WSIB

☐ Communicable Disease: If yes, has the communicable disease been reported to Public Health as required by law? ☐ Yes ☐ No

Nature of Illness/Injury (i.e. a general statement of a person's illness or injury in plain language without any technical medical details, including diagnosis or symptoms):

____

Date of First Visit: __________ Date of Most Recent Visit: __________ Date of Next Visit: __________

Was the employee referred to a specialist? ☐ Yes ☐ No

Is, or was the employee hospitalized? ☐ Yes ☐ No From: ____________ to: ____________

Date Disability Commenced: ________________ Expected Date of Return: ______________

Please describe treatment plan:

____

Anticipated Date of Return: ______________ ☐ Regular ☐ Modified ☐ Modified Hours

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Section D: To be completed by physician/practitioner at time of assessment

Function	Current Ability				
Walk	☐ 0 – 15 mins.	☐ 15 – 30 mins.	☐ 30 – 60 mins.		
Sit	☐ 0 – 15 mins.	☐ 15 – 30 mins.	☐ 30 – 60 mins.		
Stand	☐ 0 – 15 mins.	☐ 15 – 30 mins.	☐ 30 – 60 mins.		
Lift	☐ Very Heavy (100+lbs)	☐ Heavy (51-100)	☐ Medium (21-50)	☐ Light (11-20)	☐ Sed. (0-10)
Push/Pull	☐ Very Heavy (100+lbs)	☐ Heavy (51-100)	☐ Medium (21-50)	☐ Light (11-20)	☐ Sed. (0-10)
Carry	☐ Both Hands	☐ Right Hand	☐ Left Hand	☐ None	Max. Weight: ____
Fine Finger	☐ Both Hands	☐ Right Hand	☐ Left Hand	☐ None	Max. Weight: ____
Dominant Hand	☐ Both Hands	☐ Right Hand	☐ Left Hand	☐ None	Max. Weight: ____
Stair Climb	☐ Continuously	☐ Frequently	☐ Occasionally		
Ladder Climb	☐ Continuously	☐ Frequently	☐ Occasionally		
Pushing/Pulling	☐ Continuously	☐ Frequently	☐ Occasionally		
Bending	☐ Continuously	☐ Frequently	☐ Occasionally		
Crouching/Kneeling	☐ Continuously	☐ Frequently	☐ Occasionally		
Driving	☐ Continuously	☐ Frequently	☐ Occasionally		
Repetitive Motion	☐ Continuously	☐ Frequently	☐ Occasionally		

Cognitive Capabilities – If applicable, please indicate limitations in cognitive function:

Coherent	☐ Yes	☐ No	
Judgment	☐ Good	☐ Adequate	☐ Poor
Concentration	☐ Good	☐ Adequate	☐ Poor
This individual can work	☐ Independently	☐ With Supervision	☐ With Assistance

Section E: Attending Physician/Practitioner Contact Information

Name: (please print) ____

Address: ______________________ Telephone: ______________ Fax: ____________

Signature: ____________________________ Date: ____________________

Thank you in advance for your assistance.

Once completed, please return to:

Mount Sinai Hospital (address above) or fax confidentially to 416-361-2663

Mount Sinai is committed to protecting your privacy. The personal information collected on this form is collected in accordance with the Occupational Health and Safety Act and the Workplace Safety and Insurance Act. It will be used and maintained by the institution for the intended purpose of providing you with Occupational Health, Safety and Wellness services. If you have any questions about the collection, use and disclosure of the personal information provided on this form, please email the OHS Department at ohsmsh@sinaihealth.ca or call ext. 1572.