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

Occupational Health and Safety
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Toronto, ON M5T 3L9
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Treating Physician/Practitioner Statement
(For use only by ONA members hired prior to January 1, 2006)

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

Name: _____ Department: _____ Job Title: _____

Address: _____ City: _____ Postal Code: _____

Phone: (H) _____ (W) _____ Supervisor/Manager: _____ 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 the 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: _____

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

Date Disability Commenced: _____ Expected Date of Return: _____

Prognosis for return to regular duties: ☐ Good ☐ Poor ☐ Uncertain

I confirm that the employee is undergoing treatment that I have prescribed: ☐ Yes ☐ No

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

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		

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: _____

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 in 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 and Safety services. If you have any questions about the collection, use and disclosure of the personal information provided on this form, please email OHS at ohsmsh@sinaihealth.ca or call ext. 1572.