

SICK LEAVE/RETURN TO WORK FORM

Note: Any costs associated with providing this information is the responsibility of the employee.

Section A- EMPLOYEE DETAILS: Employee to Complete

Employee Name: _____	Date of Birth: _____ <small>mm / dd / yyyy</small>	Contact Phone: _____
Department: _____	Supervisor: _____	Job Title: _____
<p><i>I authorize my physician to release this completed form to the Disability Management Team (for Staff) or Occupational Health Team (for Faculty) at the University of Waterloo.</i></p>		
Employee Signature: _____	Date: _____ <small>mm / dd / yyyy</small>	

Section B- SICK LEAVE DETAILS: Physician to Complete

First date of Absence: _____ <small>mm / dd / yyyy</small>	Has your patient been absent from work for a related complaint in the past 2 months? <input type="checkbox"/> yes <input type="checkbox"/> no
Please check one: <input type="checkbox"/> Patient capable of returning to work with no limitations <input type="checkbox"/> Patient is physically unable to return to work at this time	
<input type="checkbox"/> Patient is capable of returning to work with restrictions (complete Section C-Workplace Functional Capacity)	
<p><i>NB: If a modified return to work plan is required it is expected that a return to full pre-disability hours and duties will normally occur over a maximum of 6 to 8 weeks.</i></p>	
Have you discussed return to work with your patient? <input type="checkbox"/> yes <input type="checkbox"/> no	Date cleared for return to work: _____ <small>mm / dd / yyyy</small>
To modified duties/hours: _____ <small>mm / dd / yyyy</small>	To full hours/duties: _____ <small>mm / dd / yyyy</small>
If return to work is unknown at this time please provide prognosis: _____	
Follow-up appointment: <input type="checkbox"/> None required <input type="checkbox"/> As needed	Date of next apt.: _____ <small>mm / dd / yyyy</small>
Name of Physician: _____	Telephone Number: _____
Physician Signature: _____	Date: _____ <small>mm / dd / yyyy</small>

Section C- WORKPLACE FUNCTIONAL CAPACITY: This section should only be completed by the Physician when accommodation is requested.

Functional Abilities and/or Limitations: If your patient is able to remain or return to work but has any limitations, please provide the Nature of Condition and complete the applicable sections below. DO NOT include any technical or medical details such as diagnosis or symptoms. Provide a plain language general statement of the person's illness or injury.

Nature of Condition: _____

Walking: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 100 metres <input type="checkbox"/> 100-200 metres <input type="checkbox"/> Other	Standing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15-30 minutes <input type="checkbox"/> Other	Sitting: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 30 minutes <input type="checkbox"/> 30 minutes-1 hour <input type="checkbox"/> Other	Lifting from floor to waist: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kgs <input type="checkbox"/> 5-10 kgs <input type="checkbox"/> Other	Lifting from waist to shoulder: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kgs <input type="checkbox"/> 5-10 kgs <input type="checkbox"/> Other	Stair climbing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 steps <input type="checkbox"/> 5-10 steps <input type="checkbox"/> Other	Ladder climbing: <input type="checkbox"/> Full abilities <input type="checkbox"/> 1-3 steps <input type="checkbox"/> 4-6 steps <input type="checkbox"/> Other
<input type="checkbox"/> Bending, twisting repetitive movement of (please specify)	<input type="checkbox"/> Work at or above shoulder activity	<input type="checkbox"/> Limited use of hand (s): Left Right <input type="checkbox"/> Gripping <input type="checkbox"/> <input type="checkbox"/> Pinching <input type="checkbox"/> <input type="checkbox"/> Other <input type="checkbox"/>	<input type="checkbox"/> Limited pushing/pulling with: <input type="checkbox"/> Left arm <input type="checkbox"/> Right arm <input type="checkbox"/> Other	<input type="checkbox"/> Potential side effects from medications (please specify) Do not include names of medications	Cognitive/Psychological: <input type="checkbox"/> Difficulties performing simple and repetitive tasks <input type="checkbox"/> Problems maintaining focus/concentration on the job <input type="checkbox"/> Limited ability to perform complex and varied tasks <input type="checkbox"/> Reduced energy and pace required for the job <input type="checkbox"/> Difficulty maintaining healthy co-worker relationships	

Additional Comments on limitations: _____

From the date of this assessment, the above will apply for approximately: 1-2 days 3-7 days 8-14 days 14+

Physician's Signature: _____ Date: _____

Instructions for Completion

For absences of five working days or longer, have your Physician complete this UWaterloo Sick Leave/Return to Work form. In some cases, managers may (in consultation with Human Resources) request employees to provide the UWaterloo Sick Leave/Return to Work form for shorter absences.

Once completed, this document should not be provided to your Manager/Chair.

Staff should return the completed document to the Disability Advisor located at Human Resources in East Campus 1 or by Fax # (519)888-4377 or scan and email to: absent@uwaterloo.ca. You may choose to send the form directly to the Occupational Health Nurse as noted below.

Faculty should return their documents directly to the Occupational Health Nurse as noted below.

Email: lbrogden@uwaterloo.ca. Or Telephone: 519-888-4567 ext. 36264

Email: kparkinson@uwaterloo.ca Or Telephone: 519-888-4567 ext.30338

Occupational Health Confidential fax: 519- 888- 4373

Employee's Responsibilities

- Any costs associated with providing this information is the responsibility of the employee.
- Complete Employee Section A of the document.
- Provide this document to your treating Physician for completion and discuss the information requirements.
- Review the completed form to ensure only the required information is provided (not diagnosis).
- Upon completion, return the document as instructed above in a timely manner.

University's Responsibilities

- This form provides general information about your abilities and limitations to assist with the planning of an early and safe return to work.

Guidance for Physicians

- Complete the Physician Section B. Section C should **only** be completed when your patient requires accommodation.
- The employer and employee will use this information to plan the employee's early and safe return to work.
- Their return to work plans will reflect the abilities and limitations you have noted and presume that no clinical contraindications exist for other work activities; therefore it is crucial that all sections be completed in full when accommodation is required.
- **Diagnostic or confidential information must not be included.** Nature of Condition information should be restricted to the general statement of a person's illness or injury in plain language without any technical/medical details such as diagnosis or symptoms.
- **Once you have received this document, please provide the completed form promptly to your patient.**