UNIVERSITY OF WATERLOO

SICK LEAVE/RETURN TO WORK FORM

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

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Section A- EMPLOYEE DETAILS: Employee to Complete

Employee Name: ____________ Date of Birth: __/__/____ (dd / mm /yyyy) Contact Phone: ____________

Department: ____________ Supervisor: ____________ Job Title: ____________

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.

Employee Signature: ____________ Date: __/__/____ (dd / mm /yyyy)

Section B- SICK LEAVE DETAILS: Physician to Complete

First date of Absence: __/__/____ (dd / mm /yyyy) Has your patient been absent from work for a related complaint in the past 2 months? ☐ yes ☐ no

Please check one: ☐ Patient capable of returning to work with no limitations ☐ Patient is physically unable to return to work at this time
☐ Patient is capable of returning to work with restrictions (c**omplete Section C-Workplace Functional Capacity)**

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.

Have you discussed return to work with your patient? ☐ yes ☐ no Date cleared for return to work: __/__/____ (dd / mm /yyyy)

To modified duties/hours: __/__/____ (dd / mm /yyyy) To full hours/duties: __/__/____ (dd / mm /yyyy)

If return to work is unknown at this time please provide prognosis: ____________

Follow-up appointment: ☐ None required ☐ As needed Date of next apt.: __/__/____ (dd / mm /yyyy)

Name of Physician: ____________ Telephone Number: ____________

Physician Signature: ____________ Date: __/__/____ (dd / mm /yyyy)

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

<u>Functional Abilities and/or Limitations:</u> 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:	**Standing:**	**Sitting:**	**Lifting from floor to waist:**	**Lifting from waist to shoulder:**	**Stair climbing:**	**Ladder climbing:**
☐ Full abilities	☐ Full abilities	☐ Full abilities	☐ Full abilities	☐ Full abilities	☐ Full abilities	☐ Full abilities
☐ Up to 100 metres	☐ Up to 15 minutes	☐ Up to 30 minutes	☐ Up to 5 kgs	☐ Up to 5 kgs	☐ Up to 5 steps	☐ 1-3 steps
☐ 100-200 metres	☐ 15-30 minutes	☐ 30 minutes-1 hour	☐ 5-10 kgs	☐ 5-10 kgs	☐ 5-10 steps	☐ 4-6 steps
☐ Other	☐ Other	☐ Other	☐ Other	☐ Other	☐ Other	☐ Other

☐ Bending, twisting repetitive movement of (please specify)	☐ Work at or above shoulder activity	☐ Limited use of hand (s): Left / Right	Limited pushing/pulling with:	☐ Potential side effects from medications (please specify) Do not include names of medications	**Cognitive/Psychological:**
		☐ Gripping ☐	☐ Left arm		☐ Difficulties performing simple and repetitive tasks
		☐ Pinching ☐	☐ Right arm		☐ Problems maintaining focus/concentration on the job
		☐ Other ☐	☐ Other		☐ Limited ability to perform complex and varied tasks
					☐ Reduced energy and pace required for the job
					☐ 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+ days

Physician's Signature: ____________ Date: ____________

The University of Waterloo gathers and maintains information used on this form for the purposes of supporting the University's income continuance programs. Information will be protected, used, and released in compliance with applicable law, including but not limited to Ontario's Freedom of Information and Privacy Protection Act, RSO 1990, c F.31, Workplace Safety and Insurance Act (S.O. 1997, c.16) and Occupational Health and Safety Act (R.S.O. 1991, c.0.1) and UWaterloo Policies. Questions about the collection, use and disclosure of information on this form should be directed to the Disability Benefits Specialist, University of Waterloo, 200 University Avenue West, Waterloo, Ontario, Canada N2L 3G1

UNIVERSITY OF WATERLOO

SICK LEAVE/RETURN TO WORK FORM

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 Benefits Specialist located in East Campus 1 (EC1) 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.

Karen Parkinson, Occupational Health Nurse, Email: occupationalhealth@uwaterloo.ca
Telephone: 519-888-4567 ext. 40538 or ext. 40551
Occupational Health Confidential fax: 519- 888- 4377

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.
- This form will only be used for the purposes of administering sick leaves, managing return to work, and developing reasonable accommodation solutions.

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.**

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