Memo to employee absent or requiring accommodation due to an Injury at Work (IAW)

If your injury/Illness did not occur at work, please discontinue using this package and instead use the Non-Occupational injury/Illness package

You make an essential contribution to the Company's success through your daily work. When you are absent, or require accommodation, your manager has to make adjustments in work assignments. As a result, any information your physician can provide as to your eventual return to work, either full-time, part-time, or with restrictions during recovery, will be very useful.

Please note that Karis Disability Services does not subscribe to WSIB insurance. If your injury resulted in medical attention, time off work or modified work/hours, please have the enclosed form completed.

To be eligible for benefits under the IAW plan, you must comply with the following conditions, failure to do so may result in suspension of your claim.

Medical reports:

a) Seek immediate medical attention (family doctor, urgent care or emergency dept). Medical attention must occur within the first 24-hour period after an Injury at Work.

b) COMPLETE the Accident Report Form P-5:1 within 24 hours from the incident and provide to your supervisor.

c) COMPLETE the first section of the attached ATTENDING PHYSICIAN'S STATEMENT before submitting it to your treating physician or specialist.

d) Have your treating physician or specialist fill out the second section of the ATTENDING PHYSICIAN'S STATEMENT.

e) To submit the completed and signed ATTENDING PHYSICIAN'S STATEMENT Form, please upload it to our web portal when initiating a new claim on our website at https://www.acclaimability.com/start-a-claim. Alternatively, you can fax it to 1-866-486-8663 or email it to medical@acclaimability.com. You may also ask your physician or specialist to do so on your behalf.

Medical treatment:

a) You must receive appropriate MEDICAL treatment during your absence or work accommodation.

b) Initial treatment should be provided by a qualified medical practitioner. Treatment by a health care practitioner other than a physician—a chiropractor or psychologist, for example—is acceptable on the condition that a diagnosis has first been made by a qualified medical practitioner and that the nature and duration of the treatment have been specified by this physician.

Acclaim:

a) During your absence or work accommodation, Acclaim may contact your treating physician or specialist, or may contact you, to obtain additional information on your medical condition, treatments and stage of recovery.

b) During your absence or work accommodation, Acclaim may ask you to see a designated consulting physician to confirm a diagnosis, prescribed treatment, estimated length of absence or restrictions. Failure to attend or to co-operate with the exam without a valid reason may result in suspension of your claim.

Confidentiality:

All personal health information such as the diagnosis/medical condition is confidential. Only information such as the expected return to work date/work restrictions are provided to Karis Disability Services by Acclaim.

Employee and Family Assistance Program (EFAP)

Short-term counselling services are available on a confidential, voluntary basis to Karis Disability Services employees experiencing personal difficulties.
This service can be reached through Homewood Health by calling 800-663-1142, 888-384-1152 (TTY) or 604-689-1717 (collect). You can also visit their website at HomeWeb.ca

Communication:

If you plan on travelling or residing somewhere other than your primary residence during your medical absence or work accommodation, you must notify your supervisor at least one week in advance. Your supervisor will then inform the appropriate Abilities Team member, and medical advice will be sought from Acclaim.

Responsibility:

a) You should follow the advice of your treating physician and/or Acclaim Ability and take steps to ensure a quick and complete recovery.

b) Performing activities that are incompatible with your disability or working at other employment may result in the suspension of your claim.

c) You are responsible in meeting with your treating physician on a monthly/regular basis to update your medical status and discuss health related concerns associated with a successful return to work.

d) All treatment plans recommended by the treating physician must be adhere to; failure to do so may result in a suspension of your claim.

e) Ongoing communication between you and Acclaim Ability is fundamental in expediting a successful recovery and a smooth transition back into the workforce.

Light or modified duty:

If you are medically approved to perform light or modified duties, your manager / supervisor will do what they can to accommodate your return depending on the availability of light or modified duties.

Cost of completion of forms:

Acclaim Ability will reimburse costs associated with the completion of the initial medical form. Please attach your invoice and receipt to the completed form.

ATTENDING PHYSICIAN STATEMENT (Medical Form for Injuries at Work)

If your injury/Illness did not occur at work, please discontinue completing this form and instead use the Non-Occupational injury/Illness package

(Please print clearly in ink)

TO BE COMPLETED BY EMPLOYEE

Employee's Name _____ Pronouns _____ Phone No._____ Employee ID # _____
(Last name first, in full)

I have access to a printer and am able to print all required medical forms: ☐YES ☐ NO Personal Email Address: _____

Check ONE: ☐ Left Hand dominant or ☐ Right Hand dominant or ☐ Ambidextrous

Date you first sought medical attention for this injury: |__|__|__|__|__|__|__|__|
Day Month Year

Were you hospitalized? ☐ Yes ☐ No
If YES, name of the hospital/institution_____ from |__|__|__|__|__|__|__|__| to |__|__|__|__|__|__|__|__|
Day Month Year Day Month Year

Are you claiming or receiving any other disability, wage loss and/or retirement benefits (e.g. CNESST, CPP/QPP, auto insurance, other)? ☐ Yes ☐ No
Are you working or volunteering in any capacity? ☐ Yes ☐ No
Are you receiving wages from any source? ☐ Yes ☐ No
Are you attending any educational course, program or institution? ☐ Yes ☐ No
If yes to any of the above, please provide details of these items on a separate page and include any confirming documents, claim numbers, etc.
If an accident caused your disability, indicate date |__|__|__|__|__|__|__|__| , WHERE and WHAT happened:
Day Month Year

_____
_____
_____

AUTHORIZATION

I, _____hereby authorize (Name of physician, hospital, clinic or any other medical or health care provider or facility) _____, to release to Acclaim Ability Management ("Acclaim") or its representatives or agents, any and all medical, employment or vocational information or records with respect to my absence from work/or my need for modified or accommodated work (including any appeal I might institute) and for the purpose of Acclaim's evaluation, administration and management on behalf of my employer in relation to my medical absence from work/or my need for modified or accommodated work from Karis Disability Services, including assessing my ability to return to work and my potential need for accommodation. I further authorize Acclaim or its representatives or agents to disclose any such information obtained in respect of my absence from work/or my need for modified or accommodated work to any physician, clinic or any other medical or health care provider or facility for such purposes. I understand that my refusal or withdrawal of consent may delay the provision or result in the denial of my claim. I declare that the information provided in this authorization and any statements provided in any personal or telephone interview relating to my claim are/will be true, complete and accurate. In the event I elect to pursue legal proceedings in relation to my claim, or in respect of any matters arising out of Acclaim's performance of the services described in this authorization, I acknowledge and agree that my sole cause of action will be against my employer and that I have no claim against Acclaim. In the event I have long term disability ("LTD") benefits through my employer, I do not return to work, and I submit an application for LTD benefits to Sunlife, I understand and authorize that all documents contained in and that are relevant to my entire claim file will be disclosed to Sunlife and will form part of my LTD file. I acknowledge that the services provided by Acclaim will not in any way be construed as an admission of liability by Sunlife or acceptance of a claim for the payment of LTD benefits, if I have this benefit through my employer.

This authorization shall remain valid for the duration of my claim with Acclaim unless revoked in writing by me. Any copy of this authorization shall be as valid as the original.

_____ _____ _____
Employee Name (Printed) Employee Signature Date

TO BE COMPLETED BY ATTENDING PHYSICIAN

Karis Disability Services does not subscribe to WSIB insurance. Health Care Providers will be compensated for the completion of the enclosed forms by Acclaim Ability Management Inc using WSIB guidelines. Please include the invoice with the completed form if applicable.

INCIDENT DATES AND DETAILS

Date of Accident/injury:_____ Date of examination by Physician: _____

Location of assessment: ☐ Emergency Department ☐ Office Assessment ☐ Walk-in-clinic ☐ Other

Date deemed totally disabled from work (if applicable): _____

Employee Name: *KARIS DISABILITY SERVICES*

Is this injury or illness work related: ☐ Yes ☐ No

Have you treated this patient in the past for this type of injury/Illness? ☐ Yes ☐ No If yes, what was the recovery outcome (e.g. fully recovered, partially recovered, long term limitations)

_____

What is your understanding of how this injury or re-injury occurred?

_____

_____

_____

INJURY DETAILS, CHECK ALL THAT APPLY:

Location	Body Part				Injury
☐ right	☐head	☐ arm	leg	☐ hip	☐ strain
☐ left	☐ face	☐ shoulder	☐ calf	☐ back	☐ abrasion
☐ upper	☐brain	☐elbow	☐ankle	☐ abdomen	☐ sprain
☐ lower	☐ eyes	☐ forearm	☐ thigh	☐ chest	☐ fracture
☐n/a		☐ finger	☐knee		☐ bruise
		☐ hand	☐ heel		☐ laceration
☐ ears		☐ wrist	☐foot		☐burn
☐ teeth			☐ toe		☐ puncture
☐ neck	☐ other specify:				☐ pull
☐ chest					☐tear
					☐ other specify:

Patient's Present Complaints (subjective complaints): _____

Physical Examination (objective findings): _____

Are there abnormal signs for any of the following: Active ROM, Passive ROM, Gait, Strength, Sensation, Reflexes, Other

If yes, please describe: _____

Are you aware of any pre-existing or other conditions that may delay recovery ☐ Yes ☐ No If yes, please explain _____

Diagnosis/ Working Diagnosis: _____

TREATMENT PLAN

Is there a medical treatment plan currently in place? ☐ Yes ☐ No If no, why? _____

Treatment Plan
Provide your proposed treatment plan for this patient
(Include goals, duration, frequency, etc.)

Medication(s) Prescribed
Provide prescription details and anticipated medication
Adverse effects that could possibly impact ability to Return to Work.

Assistive Devices Prescribed
Provide details (crutches, orthotic supports, etc.)

Treatment Plan/ Medication Details:

_____

_____

_____

Has any investigated testing been completed? ☐ None ☐ Labs ☐ X-rays ☐ Ultrasound ☐ MRI ☐ CT Scan ☐ EMG/NCS ☐ Other

Have any referrals been made? If yes, please indicate the type of treatment recommended and **enclose a copy of the referral with this form**:

☐ Chiropractor ☐ Massage Therapy ☐ Physiotherapist ☐ Occupational Therapist ☐ Other _____

Is the employee compliant with the prescribed/recommended treatment plan? ☐ Yes ☐ No

PROGNOSIS AND RETURN TO WORK

At this time can your patient return to work full duties effective immediately? ☐ Yes ☐ No If yes, please stop here. If no, please respond to the following questions:

If employee cannot return to full duties, can the employee return to work on modified duties: ☐ Yes ☐ No

Date to begin modified duties: _____ Expected length of time modifications will be required: _____

To be completed by licensed Physician even if NO return to work is recommended:

FUNCTIONAL ABILTIIES:

Walking (continuously):	□ up to 30 min;	□ up to 1 hour;	□ no restriction;	□ Other (e.g. uneven ground) _____	
Standing (continuously):	□ up to 30 min;	□ up to 1 hour;	□ no restriction;	□ Other _____	
Sitting (continuously):	□ up to 30 min;	□ up to 1 hour;	□ no restriction;	□ Other _____	
Lifting floor to waist:	□ up to 20 lbs;	□ up to 30 lbs	□ up to 40 lbs;	□ no restriction;	□ other _____
Lifting waist to shoulder:	□ up to 20 lbs;	□ up to 30 lbs	□ up to 40 lbs;	□ no restriction;	□ other _____
Carry:	□ up to 20 lbs;	□ up to 30 lbs	□ up to 40 lbs;	□ no restriction;	□ other _____
Push/Pull:	□ up to 20 lbs;	□ up to 30 lbs	□ up to 40 lbs;	□ no restriction;	□ other _____
Bending	□ up to 4 times/day	□ up to 8 times/day	□ no restriction;	□ Other _____	
Twisting	□ up to 4 times/day	□ up to 8 times/day	□ no restriction;	□ Other _____	
Stair climbing:	□ unable	□ 2 – 3 steps only;	□ own pace	□ assisted	□ no restriction
Ladder climbing:	□ unable	□ 2 – 3 steps only;	□ own pace	□ assisted	□ no restriction
Able to drive	☐ up to 2 hours	☐ up to 4 hours;	☐ no restriction	☐ other _____	
Employee is:	□ Left handed	□ Right handed	□ Ambidextrous		
Limited ability to used **left** hand to:		□ hold objects;	□ grip;	□ type;	□ write
Limited ability to used **right** hand to:		□ hold objects;	□ grip;	□ type;	□ write
Completely unable to use **left** hand to:		□ hold objects;	□ grip;	□ type;	□ write
Completely unable to use **right** hand to:		□ hold objects;	□ grip;	□ type;	□ write

Limitations due to medication(s) _____

Able to perform Cardiopulmonary Resuscitation (CPR)? □ Yes □ No

Able to perform Physical Restraint techniques? □ Yes □ No

Able to work alone □ Yes □ No

Hours per day: □ 4 hours □ 6 hours □ 8 hours □ 10 hours □ 12 hours □ no restriction

Other clinically assessed limitations including cognitive limitations (if applicable):

_____

Expected date of Return to Work **Full hours and duties** _____ Next appointment: _____
Day Month Year Day Month Year

Additional Comments:

ATTENDING PHYSICIAN'S INFORMATION

NOTICE TO PHYSICIAN: *Any information provided by you to* ***Acclaim Ability Management*** *regarding this claim may be disclosed to the claimant and/or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the claimant or in harm to a third party.*

Physician's Name (please print): _____ Telephone: _____

Address:_____ Fax:_____

Signature: _____ Specialty:_____ Date: _____