



## Memo to employee absent or requiring accommodation due to non-occupational Injuries/Illness

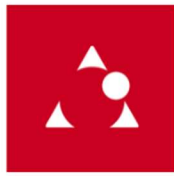
**If your injury occurred at work, please discontinue using this package and instead use the Injury at Work package**

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.

If you require workplace accommodation, have been absent from work for 10 or more calendar days, or have exhausted your Personal Emergency Leave, please continue using this package. Otherwise, please contact your manager for further information and next steps.

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

- Medical reports:**
- a) COMPLETE the first section of the attached ATTENDING PHYSICIAN'S STATEMENT before submitting it to your treating physician or specialist.
  - b) Have your treating physician or specialist fill out the second section of the ATTENDING PHYSICIAN'S STATEMENT.
  - c) 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](mailto: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](http://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:**
- All costs associated with the completion of the initial medical form related to your Medical Leave or work accommodation claim are the responsibility of you, the employee.



## ATTENDING PHYSICIAN STATEMENT (Medical Form for non-occupational Injuries/Illness)

If your injury occurred at work, please discontinue completing this form and instead use the Injury at Work 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

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

The patient is responsible for any charges made for completion of this form, unless prohibited by law. Please return completed form to your patient.

### ILLNESS INFORMATION

Nature of the illness or injury: \_\_\_\_\_

Date illness or injury began: \_\_\_\_\_ Date of examination by Physician: \_\_\_\_\_

Date deemed totally disabled from work (if applicable): \_\_\_\_\_

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

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

Please send completed form to **Acclaim Ability Management** at 1-866-486-8663 or [medical@acclaimability.com](mailto:medical@acclaimability.com)

Employee Name:

KARIS DISABILITY SERVICES

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

If **yes**, please describe the employee's current limitations (please use the abilities section if applicable) If **NO**, please provide the medical contraindications to a modified return to work:

Expected length of time modifications will be required: \_\_\_\_\_

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

If disability is related to pregnancy, please indicate the expected date of delivery \_\_\_\_\_  
Day Month Year

I see the patient every \_\_\_\_\_ (day, week, etc.) Date of most recent examination \_\_\_\_\_  
Day Month Year

Has patient ever had a similar condition? ☐ Yes ☐ No If yes, state when and describe:

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

**FUNCTIONAL ABILITIES:**

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

**COGNITIVE ABILITIES:**

Deadline Pressures:	<input type="checkbox"/> limited capacity	<input type="checkbox"/> unable to perform	<input type="checkbox"/> no restriction;	<input type="checkbox"/> Other _____
Attention:	<input type="checkbox"/> limited capacity	<input type="checkbox"/> unable to perform	<input type="checkbox"/> no restriction;	<input type="checkbox"/> Other _____
Memory:	<input type="checkbox"/> limited capacity	<input type="checkbox"/> unable to perform	<input type="checkbox"/> no restriction;	<input type="checkbox"/> Other _____
Reasoning:	<input type="checkbox"/> limited capacity	<input type="checkbox"/> unable to perform	<input type="checkbox"/> no restriction;	<input type="checkbox"/> Other _____
Problem Solving:	<input type="checkbox"/> limited capacity	<input type="checkbox"/> unable to perform	<input type="checkbox"/> no restriction;	<input type="checkbox"/> Other _____

Other clinically assessed limitations:

Employee Name: \_\_\_\_\_

KARIS DISABILITY SERVICES

**If Nature of condition is Psychological/Mental Health, please advise if criteria for ICD -10- CM/ DSM 5 was evaluated:**

☐ Yes ☐ No

**Treatment**

If hospitalized, name of the hospital/institution \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_  
Day Month Year Day Month Year

Surgery? ☐ Yes ☐ No (If yes, state surgical procedure) \_\_\_\_\_

☐ Performed ☐ Planned Date of Surgery \_\_\_\_\_ Anesthetic: ☐ Local ☐ General  
Day Month Year

List medications currently prescribed and dosage \_\_\_\_\_

Therapy? ☐ Yes ☐ No If yes, indicate type (e.g. physiotherapy, psychotherapy, etc.) \_\_\_\_\_

Frequency: ☐ Daily \_\_\_\_\_ ☐ per week ☐ Other \_\_\_\_\_

Location: ☐ Outpatient ☐ Therapist's Office ☐ Physician's Office ☐ Home

Summary of patient's response to treatment:

**Prognosis**

Have you discussed a Return to Work Plan with your patient? ☐ Yes ☐ No

If no, why not? \_\_\_\_\_

If yes, please provide details about the Return to Work Plan including recommendations for modified hours and/or modified duties:

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: \_\_\_\_\_