NVACanada

Memo to employee absent due to disability

Please read Carefully.
You make an essential contribution to the Company's success through your daily work. When you are absent, your manager has to make adjustments in work assignment. 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.

To be eligible for benefits under the Disability plans, you must comply with the following conditions.
IMPORTANT: Failure to do so may result in suspension of disability benefits.

Medical reports:

a) COMPLETE the first section of the attached ATTENDING PHYSICIAN'S STATEMENT before submitting it to your treating physician or specialist, as the case may be.
b) Have your treating physician or specialist fill out the second section of the ATTENDING PHYSICIAN'S STATEMENT.
c) Return the completed and signed ATTENDING PHYSICIAN'S STATEMENT Form to Acclaim by fax at 1-866-486-8663 or by email to medical@acclaimability.com (or ensure the physician or specialist does so).

Medical treatment:

a) You must receive appropriate MEDICAL treatment during your absence.
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, 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, 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 disability benefits.

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 NVA Canada by Acclaim.

Employee and Family Assistance Program (EFAP)

Short-term counselling services are available on a confidential, voluntary basis to NVA Canada employees experiencing personal difficulties.
This service can be reached through **ComPsych GuidanceResources®** by dialling 866.483.1491. Or visit the website at guidanceresources.com App: GuidanceNowSM Web ID: NVACanada

Communication:

If you plan on travelling or residing somewhere other than your primary residence during your medical absence from work, you must give at least one week's notice to your Human Resources Contact, who will request medical advice from Acclaim. Failure to comply with this condition may result in suspension of benefits.

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 benefits.
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 adhered to; failure to do so may result in a suspension of benefits.
e) Ongoing communication between you and Acclaim 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 hospital 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 any medical forms related to your medical leave claim are the responsibility of you, the employee.

acclaim GESTION DES CAPACITÉS

ATTENDING PHYSICIAN STATEMENT

(Medical Form)

(Please print clearly in ink)

TO BE COMPLETED BY EMPLOYEE

Employee's Name_____ Phone No._____
(Last name first, in full)

Address_____
(Street Number and Name) (Apt. No.) (City/Town) (Province) (Postal Code)

Date of Birth: _____ Language: ☐ E ☐ F ☐ Other Sex: ☐ M ☐ F
Day Month Year

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

Are you claiming or receiving any other disability, wage loss and/or retirement benefits (e.g. WSIB, 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 claim for Medical Leave benefits ("ML benefits", 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 from NVA Canada, including assessing my ability to return to work and my potential need for accommodation. I further acknowledge being informed that the obligation to pay ML Benefits is solely the responsibility of my employer. I further authorize Acclaim or its representatives or agents to disclose any such information obtained in respect of my ML claim 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 ML claim. I declare that the information provided in this authorization and any statements provided in any personal or telephone interview relating to my ML claim are/will be true, complete and accurate. In the event I elect to pursue legal proceedings in relation to my ML benefits 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 do not return to work and I submit an application for long term disability ("LTD") benefits to Canada Life, I understand and authorize that all documents contained in and that are relevant to my entire ML claim file will be disclosed to Canada Life 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 Canada Life or acceptance of a claim for the payment of LTD benefits.

This authorization shall remain valid for the duration of my claim with Acclaim unless revoked in writing to 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: _____

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

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 Has a Form 8 been submitted to WSIB? ☐ 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:**

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 _____
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 _____	
Able to operate heavy machinery:	☐ 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
Hours per day:	□ 4 hours	□ 6 hours	□ 8 hours	□ 10 hours	□ 12 hours	□ no restriction

COGNITIVE ABILITIES:

Deadline Pressures:	□ limited capacity	□ unable to perform	□ no restriction;	□ Other _____
Attention:	□ limited capacity	□ unable to perform	□ no restriction;	□ Other _____
Memory:	□ limited capacity	□ unable to perform	□ no restriction;	□ Other _____
Reasoning:	□ limited capacity	□ unable to perform	□ no restriction;	□ Other _____
Problem Solving:	□ limited capacity	□ unable to perform	□ no restriction;	□ Other _____

Other clinically assessed limitations: _____

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 _____x 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-Time _____ 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: _____