CALIFORNIA CLOSETS®

# Memo to employee absent due to disability

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 an approved sick leave, you must comply with the following conditions.
IMPORTANT: Failure to do so may result in suspension of your absence support and paid sick time.

***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 absence support and sick time.

***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 California Closets by Acclaim.

***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 your absence support and sick time.

***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 absence support and sick time

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 absence support and sick time.

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 HR representative and 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 claim are the responsibility of you, the employee.

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# Medical Certificate (Medical Monitoring)

(Please print clearly in ink)

**TO BE COMPLETED BY ASSOCIATE**

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
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

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**AUTHORIZATION**

1. I _____ consent to oral, written or electronic communication and information exchange regarding my medical restrictions and limitations between Acclaim Ability Management (Acclaim), any independent evaluators, agents and consultants acting on behalf of Acclaim, and their providers, any health care practitioner, licensed physician, medical practitioner, hospital, clinic, medical or medically related facility, rehabilitation providers, or any other organization, institute or person which has records or reports related to my health, and rehabilitation. This pertains to my current absence from work and/or the current referral to Acclaim for Disability Management services and may include the results of consultations or assessments obtained during the service process. I understand that the aforementioned communication and information, portions thereof, and/or resulting recommendations that relate to my abilities or limitations to perform my job duties (excluding specific reference to diagnosis or related personal information), may be communicated to California Closets. (the "Company").

2. Acclaim's role in the provision of Disability Management Services is to support employees throughout disability claims and provides assistance during return-to-work planning.

3. I acknowledge and understand that in the event of any dispute with California Closets, including the delivery of a demand letter, litigation, grievance, claim under any human rights or employment legislation or any cause of action, claim or demand against California Closets., Acclaim may exchange with California Closets. a complete copy of my disability file including all case notes, medical reports and any other medical documentation contained therein.

A photocopy or facsimile of this authorization shall be as valid as the original.

This consent is valid until I return to full hours and duties at work, until or unless my business relationship with the Company has been formally severed. Notwithstanding the foregoing, including the formal termination of my employment with the Company, clause 3 in this consent will survive and remain in full force and effect. It may be withdrawn at any time with written notification to Acclaim.

DATED AT _____ ON THIS _____ DAY OF _____ YEAR _____.

Name of Employee: _____

Signature of Employee: _____

Address of Employee: _____

**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: _____

Please send completed form to ***Acclaim Ability Management*** at 1-866-486-8663 or medical@acclaimability.com

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

**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**

What functional limitations affect the patient's ability to perform his/her normal activities, including work?

If diagnostic studies were done, please indicate

Type_____ Date(s)_____ Result(s)_____

Are any further investigations planned? ☐ Yes ☐ No (If yes, please state date and type).

Names of other physicians involved with this patient's care

**Treatment**

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

Can your patient return to work with accommodations to support the limitations indicated above? ☐ Yes ☐ No

If no, what are the medical risks to participating in a modified return to work?

If yes, what is the anticipated duration of the modified work? _____

Is it anticipated that this employee will recover from this condition and resume full functional ability again in the future: ☐ Yes ☐ No

If recovery is expected, please identify tentative date: _____

If no, what are the factors affecting your patient's progress?

If yes, is the prognosis confirmed by a specialist and supported with objective medical testing available on file?? ☐ Yes ☐ No

***If yes, please include the report(s).***

If yes, anticipated date of Return Full-Time and full duties: _____
Day Month Year

If no, please advise of anticipated gains in your patient's recovery, and a timeline for those gains:

Next appointment: _____
Day Month Year

**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: _____