



Memo to Associate: Medical Leave of Absence

Please read carefully

You make an essential contribution to **Napoleon's** success through your daily work. When you are absent, your manager has to make adjustments in work assignment. As a result, you are required to provide information from your physician to support your absence and your eventual return to work, either full-time, part-time, or with restrictions during recovery.

To be eligible medical leave of absence support, you must comply with the following conditions.

IMPORTANT: Failure to do so may impact the status 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, as the case may be.
- b) Have your treating physician or specialist fill out the second section of the ATTENDING PHYSICIAN'S STATEMENT Form.
- c) Return the completed and signed ATTENDING PHYSICIAN'S STATEMENT Form to **Acclaim** by the due date indicated above by fax at [1-866-486-8663](tel:1-866-486-8663) or email to: faxes@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, 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:

During your absence, **Acclaim** may contact your treating physician or specialist with your consent, or may contact you, to obtain additional information on your medical condition, treatments and stage of recovery.

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 **Napoleon** by **Acclaim**.

Associate Assistance Program (EAP)

Short-term counselling services are available on a confidential, voluntary basis to **Napoleon** associates experiencing personal difficulties. This service can be reached through Lifeworks by dialling 1.877.207.8833
username: napoleon **password:** wellness

Communication:

If you plan on leaving your usual place of residence, you must give at least one week's notice to your Human Resources Contact, who will request medical advice from **Acclaim**. Failure to do so may impact the status of your claim.

Responsibility:

- a) You should follow the advice of your treating physician and/or **Acclaim** 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 impact the status of your claim.
- c) You are responsible in meeting with your treating physician on a 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 impact the status of your claim.
- 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 Benefits Team 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 medical leave of absence claim are the responsibility of you, the associate.

NOTE TO ASSOCIATE: RETAIN THIS MEMO FOR REFERENCE

Acclaim – Medical Leave of Absence Information Memo





Attending Physician Statement (Medical Form)

(Please print clearly in ink)

TO BE COMPLETED BY EMPLOYEE

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

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 of Absence ("MLOA", 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 **Napoleon**, 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 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 MLOA. I declare that the information provided in this authorization and any statements provided in any personal or telephone interview relating to my MLOA are/will be true, complete and accurate. In the event I elect to pursue legal proceedings in relation to my MLOA, 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 MLOA 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** and **Canada Life** 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.

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 claim submitted to WCB? 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 ABILITIES:

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 _____

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 _____

Squatting: unable occasionally no restriction other _____

Bending: unable occasionally 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

Can the associate work in excess of 40 hours per week? Yes No

If NO, what is the objective medical risk?

How many consecutive days in a row an associate work? _____

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

Employee Name: _____

Napoleon

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 _____
Day Month Year

Next appointment: _____
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: _____