Memo to colleagues requesting a workplace accommodation due to medical reasons

Your employer is committed to ensuring your safety while in the workplace. As a result, any information your physician can provide regarding your request for an accommodation, will be useful.

When requesting an accommodation due to a medical condition, you must provide the following.
IMPORTANT: Failure to do so may result non-support of your accommodation.

Medical reports:

a) COMPLETE the first section of the attached Medical Certificate (Accommodation Request) form before submitting it to your treating physician or specialist.

b) Have your treating physician or specialist fill out the second section of the Medical Certificate (Accommodation Request) form. Specialist reports confirming your medical condition may also be required.

c) Return the completed and signed Medical Certificate (Accommodation Request) form to Acclaim by fax at 1-866-486-8663 or by email to medical@acclaimability.com .

Medical treatment:

a) You must follow medical advice and any reasonable prescribed treatment

b) You must be under the care of a regulated healthcare practitioner in Canada.

Acclaim:

a) 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) Acclaim may ask you to see a designated consulting physician to confirm a diagnosis, prescribed treatment, and estimated duration of restrictions. Failure to attend or to cooperate with the exam without a valid reason may result in suspension of your accommodation.

Confidentiality:

All personal health information (PHI) such as the diagnosis/medical condition is confidential. Acclaim will only provide information such as the medical limitations and recommended accommodation to American Express. .

Healthy Minds Program (EFAP)

Holistic well-being, including mental health, is a top priority at American Express. American Express colleagues and their household members have access to 10 free counseling sessions through Healthy Minds. To learn more visit, amex.lyrahealth.com or call 1-800-874-3817.

Responsibility:

a) You should follow the advice of your treating physician 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 non-support of your accommodation.

c) You are responsible in remaining under the regular care of a physician 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 the accommodation.

e) Ongoing communication between you and Acclaim Ability is required.

Cost of completion of forms:

You are responsible for all costs associated with the completion of any medical forms related to your accommodation.

MEDICAL CERTIFICATE (Accommodation Request)

(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
Day Month Year

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

Nature of Accommodation being requested by employee (please be specific):

_____

_____

_____

AUTHORIZATION

I, _____, do authorize _____ any physician, hospital, clinic or any other medical or health care provider or facility to disclose my medical and health information to Acclaim Ability Management (Acclaim), which includes any independent evaluators, agents and consultants acting on behalf of Acclaim. I consent to the collection, use and disclosure of my medical and health information by Acclaim which includes any independent evaluators, agents and consultants acting on behalf of Acclaim, any health care practitioner, licensed physician, medical practitioner, hospital, clinic, medical or medically related facility, rehabilitation provider, or any other organization, institute, or person(s) which have records or reports related to my health and rehabilitation.

The above consent pertains to my current absence from work and/or my need for modified or accommodated work, and/or the current referral to Acclaim for services. These services may include the results of consultations or assessments obtained regarding my health condition.

I understand that the aforementioned communication and information, portions thereof, and/or resulting recommendation that relates to my abilities or limitations to perform my job duties (excluding specific reference to diagnosis or related personal information) may be communicated to American Express for the purposes of any one or more of the following:

1. Accommodating for my health condition with the Company;
2. Providing information for modified work with the Company;

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

By signing below, I consent to collection, use and disclosure of my personal information, including my health information, for the purposes as described above. I am aware that I can choose to provide or withhold this consent, but that my decision may affect my eligibility for health-related benefits, my right to accommodation or my ability to return to regular or modified work duties.

This consent is valid from the date signed until I return to full hours and duties at work, or on the date my business relationship with the Company has been formally severed, whichever is earlier. It may be withdrawn at any time if I provide prior written notification to Acclaim or to American Express.

_____ _____ _____
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.

It is the employee's responsibility to provide objective medical information to validate the request for work accommodations. **In order to prevent processing delays, this form must be duly completed by the employee and attending physician and returned to *Acclaim* within 14 days of the employee's request for work accommodation.** Note: The patient is responsible for any charges made for completion of this form, unless prohibited by law.

Nature of the illness or injury requiring accommodation: _____

Date illness or injury began:_____ Date of examination by Physician: _____

Date of most recent specialist assessment for condition related to the accommodation request: _____

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

Is your patient also under the care of a specialist? ☐ Yes ☐ No
If NO, why not?

_____

_____

Is a follow up appointment with the involved specialist scheduled? If so, please indicate date:_____

Recommendations from Specialist for work related restrictions/abilities:

_____

_____

_____

Please provide objective clinical evidence (including x-ray results, blood pressure, lab data and any relevant clinical findings) and medical history relevant to current medical:

_____

_____

NOTE: Please provide all clinical notes and medical reports (including specialist reports and diagnostic testing available on file), pertaining to the medical condition requiring accommodation.

Expected length of time modifications will be required: _____

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:**

_____

_____

Are there any accommodations your patient's employer could put in place to assist your patient in managing his/her condition?

_____

_____

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 _____	
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) _____

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: _____

Please specify which of the above functional or cognitive limitations affect your patient's ability to perform his/her regular work duties, as related to the accommodation request indicated by your patient on these forms

If Nature of condition is Psychological/Mental Health, please advise if criteria for ICD -10- CM/ DSM 5 was evaluated:
☐ **Yes** ☐ **No**

Prognosis

Is it anticipated that this employee will recover from this condition and resume full functional ability again? ☐ Yes ☐ No
If no, what are the factors affecting your patient's progress?

Has this employee reached Maximum Medical Recovery from this condition? ☐ Yes ☐ No
If yes, are there specialist reports to support MMR? ☐ Yes ☐ No If yes, please include the report(s).

Expected date of Return Full-Time and full 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: _____