



Memo to employee requesting workplace accommodation due to medical reasons

You make an essential contribution to the company's success through your daily work. Your employer is committed to ensuring your safety while in the workplace. As a result, any information your physician can provide as to your request for workplace accommodation, either temporary or long term, will be very useful.

When requesting a workplace accommodation due to medical concerns, you must comply with the following conditions and processes. **IMPORTANT:** Failure to do so may result non-support of your accommodation.

Medical reports:

- a) COMPLETE the first section of the attached WORK ACCOMMODATION MEDICAL QUESTIONNAIRE 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 WORK ACCOMMODATION MEDICAL QUESTIONNAIRE. Specialist reports confirming your medical condition may also be required.
- c) Return the completed and signed WORK ACCOMMODATION MEDICAL QUESTIONNAIRE 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) within 14 calendar days of submitting referral.

Medical treatment:

- a) You must receive appropriate MEDICAL treatment to address the condition requiring accommodation.
- b) 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) 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, estimated duration of restrictions. Failure to attend or to co-operate with the exam without a valid reason may result in suspension of your accommodation support.

Confidentiality:

All personal health information such as the diagnosis/medical condition is confidential. Only information such as the medical limitations and recommended accommodation are provided to Labatt Brewing Company by Acclaim.

Employee and Family Assistance Program (EFAP)

Short-term counselling services are available on a confidential, voluntary basis to Labatt Brewing Company employees experiencing personal difficulties. This service can be reached through Sun Life Lumino Health Virtual Care by dialling 1-844-342-3327 or visit the website at luminovc.dialogue.co

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 non-support of your accommodation request.
- 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 stay at work.
- d) All treatment plans recommended by the treating physician must be adhere to; failure to do so may result in a suspension of support.
- e) Ongoing communication between you and Acclaim Ability is fundamental in expediting a successful recovery / maintenance of your condition.





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 _____ (healthcare provider, licensed physician, medical practitioner, hospital, clinic, Manulife) 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 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 Labatt Brewing Company 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 Labatt Brewing Company

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.**

Nature of the illness or injury requiring accommodation: _____

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

Employee Name: _____

Labatt Brewing Company

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:**

Please specify the functional limitations or cognitive restrictions that 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

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

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 5 kg; up to 10 kg up to kg; no restriction; other _____
- Lifting waist to shoulder: up to 5 kg; up to 10 kg up to kg; no restriction; other _____
- Carry: up to 5 kg; up to 10 kg up to kg; no restriction; other _____
- Push/Pull: up to 5 kg; up to 10 kg up to kg; no restriction; other _____

Stair climbing: unable up to 3 steps; up to 6 steps; own pace assisted no restriction

Ladder climbing: unable 2 – 3 steps only; own pace assisted no restriction

Travel to work: Ability to use Public Transit YES NO Ability to Drive a Vehicle: YES NO

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 push pull

Limited ability to used **right** hand to: hold objects; grip; type; write push pull

Completely unable to use **left** hand to: hold objects; grip; type; write push pull

Completely unable to use **right** hand to: hold objects; grip; type; write push pull

Hours per day: 4 hours 6 hours 8 hours 10 hours 12 hours no restriction

Please indicate **restrictions that apply**:

Bending / Twisting / Repetitive movement (please specify): _____

Exposure to vibration: Whole body Hand/Arm _____

Work at or above shoulder level: _____

Environmental exposure (i.e. heat, cold, noise, or scents): _____

Chemical Exposure: _____

Overtime NOT restricted (may work more than 40 hours/week): _____

Overtime restricted while on modified work / modified hours: _____

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

Please specify the functional limitations or cognitive restrictions that 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

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?

Employee Name: _____

Labatt Brewing Company

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: _____
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: _____