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, LTD provider) 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 CI Financial 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 CI Financial.

_____ _____ _____
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: _____

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

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 <u>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</u>

_____

_____

_____

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

_____

_____

_____

<u>FUNCTIONAL ABILTIIES:</u>

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

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?

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: _____