Hamilton Health Sciences

Fax: 905-577-8379

Medical Certificate of Disability

Send completed form marked as "confidential" to:
Health, Safety and Wellness
Hamilton Health Sciences – King West
P.O. Box 2000, Hamilton, ON, L8N 3Z5
OR: Fax: 905-577-8379 Email: ability@hhsc.ca

The information on this form is being collected by Hamilton Health Sciences' Health and Ability Services for the purpose of adjudicating eligibility for Short Term Disability Benefits (paid sick benefits) and making recommendations for return to work. This certificate will be deemed incomplete unless all information requested in Section C is completed.

Section A: General Information

Employee Name:_____ ID #:_____Phone #:_____

Address:_____
City Province Postal Code

Date of Birth: ____/____/____ Last Day Worked: ____/____/____ Personal Email (optional): _____
DD MM YY DD MM YY

Occupation:_____Department:_____

Section B: Consent Information (to be completed by employee)

I authorize my treating, medically qualified health care professional _____ to provide Health and Ability Services with information **relative to my claim**, by completing Section C. Medical information will be kept confidential by Health and Ability Services and not disclosed to any other individual unless required by law. I understand HHS will be notified concerning my eligibility for benefits and will be provided with information relevant to my return to work and accommodations. I accept a photocopy or other reproduction of this authorization is as valid as the original.

Employee's Signature: _____ Date: ____/____/____
DD MM YY

Section C: Disability Information (to be completed by Physician or other Qualified Medical Health Care Professional)

In order to support the medical absence of this employee and facilitate his/her return to work, we require specific information. This certificate will be deemed incomplete unless all information requested in Section C is completed.

General Nature of Illness or Injury (without diagnosis or symptoms):

_____

_____

_____

Area of Injury/Illness:

			L		R	L		R	L		R	L		R
☐ Brain	☐ Ears	☐ Upper Back	☐	Shoulder	☐	☐	Wrist	☐	☐	Hip	☐	☐	Ankle	☐
☐ Head	☐ Teeth	☐ Lower Back	☐	Arm	☐	☐	Hand	☐	☐	Thigh	☐	☐	Foot	☐
☐ Face	☐ Neck	☐ Abdomen	☐	Elbow	☐	☐	Fingers	☐	☐	Knee	☐	☐	Toes	☐
☐ Eyes	☐ Chest	☐ Pelvis	☐	Forearm	☐				☐	Lower Leg	☐			

☐ Mental Health ☐ Other: _____

Symptoms began or accident happened: ____/____/____ First Visit: ____/____/____
DD MM YY DD MM YY

Illness or Injury forced cessation of work on: ____/____/____ Is this a work-related illness/injury? ____ Yes ____ No
DD MM YY **If yes, please submit a Form 8/CMS8 to WSIB**

Did you undertake an objective medical assessment that supports this illness/injury? ___ Yes ___ No

On what date did you make this medical assessment? ____/____/____ (DD MM YY)

Is your patient capable of performing the regular duties of the occupation in which he/she participated immediately before becoming ill/injured? ___ Yes ___ No

If no, please comment:

_____

_____

_____

PLEASE COMPLETE THE FOLLOWING ONLY IF THE EMPLOYEE CONTINUES TO BE OFF WORK

Is your patient undergoing treatment? ___ Yes ___ No

Please indicate the functional and/or cognitive abilities in relation to this illness/injury:

	Able to	Somewhat Able	Not Able
Stand	☐	☐	☐
Walk	☐	☐	☐
Sit	☐	☐	☐
Reach	☐	☐	☐

	Able to	Somewhat Able	Not Able
Kneel/Crouch/Squat	☐	☐	☐
Lift	☐	☐	☐
Push/Pull	☐	☐	☐
Bend/Twist	☐	☐	☐

	Able to	Somewhat Able	Not Able
Concentrate	☐	☐	☐
Multi-task	☐	☐	☐
Work with Others	☐	☐	☐
Memory Function	☐	☐	☐
Able to manage Emotional Situations	☐	☐	☐

Other Limitations:

_____

_____

Restrictions in place for: ☐ Less than 2 weeks ☐ 2-4 weeks ☐ More than 4 weeks

Full Recovery Expected? ___ No ___ Yes: ____/____/____ (DD MM YY) Date of next appointment: ____/____/____ (DD MM YY)

Additional Comments:

_____

_____

Notice to physician and/or other qualified medical health care professional: Any information provided by you to Health and Ability Services may be disclosed to the patient and/or those authorized by him/her to receive such disclosure.

Name of Health Care Provider (please print): _____

Address: _____

Phone: _____ Fax: _____

Health Care Provider's Signature: _____ Date: ____/____/____ (DD MM YY)

Physician / health care offices can bill Hamilton Health Sciences directly by forwarding the invoice, within four (4) months of the service date, via fax to 905-577-8379 or email to ability@hhsc.ca. Staff seeking reimbursement can request through the Basware/TEM process outlined on The Hub.