acclaim
ABILITY MANAGEMENT INC.

Group Health Centre

ATTENDING PRACTITIONER'S STATEMENT

Section A **Employee Information:** ***(to be completed by employee)***

Name: _____ Primary Phone #: _____

Address: _____ City: _____ Postal Code: _____

Email Address: _____

Employer: _____ Job Title: _____

LAST DAY WORKED: _____ **FIRST MISSED SHIFT:** _____

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

I authorize the physician/practitioner to disclose information to ***Acclaim Ability Management ("Acclaim")*** regarding my medical condition as it relates to my current absence from work by completing Sections C and D (below) for the purposes of validating and managing my claim for a medical leave of absence, as it relates to my fitness for work.

I understand that Acclaim will keep my medical information confidential but for the purpose of facilitating my return to work I consent to allow ***Acclaim*** to relate my claim status, my absence duration and my ability to return to work with or without restrictions to my employer. I also consent to allow my employer to share non-medical information with ***Acclaim*** as it relates to my current absence for the purpose of facilitating my return to work (if applicable).

A photocopy of this authorization is as valid as the original.

_____ _____

Signature Date

Section C: ***(to be completed by qualified medical doctor or qualified medical health professional)***

Date first assessed (insert job title): _____

Expected period of absence: _____

General nature of illness or injury
(without disclosure of diagnosis): _____

Is this absence work related: ☐ Yes ☐ No

Employee is under active treatment: ☐ Yes ☐ No

Please describe treatment provided and plan: _____
_____

Anticipated return to work date: _____

Complete recovery expected: ☐ Yes ☐ No

PLEASE TURN OVER >

Section D

Employee name: _____

We support safe and timely return to work. We are committed to working with the employer in providing modified duties to support the recovery process. Please fully complete the box(es) below.

☐ **Fit to return to all regular duties**:

Date:

☐ **Employee fit for modified work:** Please indicate specific functional limitations:

Duration: **Reassessment Date:**

☐ **Employee unfit to work:** Please describe the functional impairment that is preventing this employee from performing **all regular duties**:

Duration: **Reassessment Date:**

By affixing my signature below, I certify that I am a qualified medical health professional and that I have personally assessed and treated the above patient/employee. It is my opinion that the information is true and accurate.

Practitioner's Name: (Please Print)_____

Address: _____

Telephone: _____ Fax: _____

Signature: **Date:**

Once completed please return by confidential fax or email to *Acclaim* at:

Fax #: 1-866-486-8663 / 705.254.4462 Email: grouphealth@acclaimability.com