acclaim
ABILITY MANAGEMENT INC.

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 Sex: ___ M ___ F
Day Month Year

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 request for a workplace accommodation at Group Health Centre for the purposes of validating and managing my claim for work accommodation.

I understand that Acclaim will keep my medical information confidential but for the purpose of facilitating my return to work in an accommodated fashion. I consent to allow ***Acclaim*** to relate my claim status 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 claim for the purpose of facilitating my return to work (if applicable).

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

_____ _____
Signature Date

TO BE COMPLETED BY ATTENDING PHYSICIAN

It is the employee's responsibility to provide objective medical information to validate the request for work accommodations. The employee is also responsible to pay costs incurred in obtaining this information. (Employer will reimburse the employee up to a maximum of $50.00 for completion of this form.) This is not a request for examination, but for information taken from your chart. **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.**

General Nature of Injury or Illness:

Primary_____ Signs/Symptoms _____

Secondary_____ Signs/Symptoms _____

If Nature of Condition requiring accommodation is psychological / mental health related, please adivse if criteria for ICD-10-CM / DSM – 5 was evaluated. ___ Yes ____ No

Contributing factors/complications: _____

_____

_____

If condition is *pregnancy related*, provide expected date of delivery and current obstetrical complications:

_____

_____

Please fax completed form directly to ***ACCLAIM Ability Management*** at 705-254-4462

HISTORY

Date symptoms first appeared|__|__|__|__|__|__|__|__| Date of most recent examination|__|__|__|__|__|__|__|__|
Day Month Year Day Month Year

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

FUNCTIONAL ABILTIIES

Walking (continuously): □ up to 20 min; □ up to 1 hour; □ no restriction; □ Other (e.g. uneven ground) _____
Standing (continuously): □ up to 20 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 _____
Stair climbing: □ unable □ 2 – 3 steps only □ own pace □ assisted □ no restriction

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

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

COGNITIVE ABILITIES:

Sustain Concentration: □ No Limitation □ Specify details of duration: _____
Interact with others: □ No Limitation □ Specify details: _____
Process Instructions: □ No Limitation □ Specify details: _____
Driving / Operating Machinery: □ No Limitations □ Specify details: _____

Restrictions due to medication: □ None □ Specify details: _____

If you are recommending *a **shift accommodation***, please explain why and how the regular shift this employee worked is now medically contraindicated:

Treatment

What is the current treatment plan (including medication, therapy etc.) for this condition?

What is the employee's response to this treatment? _____

Is your patient also under the care of a specialist? Yes _____ No _____

Type of Specialist: _____

If yes, please include contact information and/or copies of consultation reports

Prognosis

Is it anticipated that this employee will recover from this condition and resume full functional ability again:
Yes_____ No_____ Unlikely _____

If yes, what is the expected timeline for recovery? _____

If no, what are the factors affecting your patient's progress?

Has this employee reached Maximum Medical Recovery from this condition: Yes_____ No_____

Are there any medical contraindications for this employee? ____Yes ____No
If yes, please outline:

Date employee expected to return to full duties: _____

Additional Comments/Accommodations Required:

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: _____ Phone No: _____
(Please print)

Address_____ Fax No: _____

Physician's Signature _____ **Specialty**_____ **Date** _____
Day Month Year

Please fax completed form directly to ***ACCLAIM Ability Management*** at 705-254-4462