acclaim
ABILITY MANAGEMENT INC.

Christian Horizons

INJURY AT WORK PACKAGE

FOR EMPLOYEES WITH FULL-TIME OR PART-TIME PERMANENT CONTRACTS

Please complete this package if your injury at work resulted in medical attention, time off work or modified duties/hours.

NOTE: *Christian Horizons has an internal insurance plan that provides specific support for an employee who has been injured at work. Christian Horizons* ***does not and is not required to subscribe to WSIB*** *insurance.* ***For a workplace injury please complete the forms attached and submit to Acclaim Ability Management at 1-866-486-8663.***

Employee Responsibilities:

- Notify your Supervisor and seek immediate medical attention within 24 hours if required (e.g. family doctor, urgent care or emergency dept.).
- Complete the enclosed Accident/Incident/Occupational Illness/Near Miss Report Form P-5:1 within 24 hours from the incident and submit the completed form to all parties listed on the form.
- Have your health care provider complete the Health Professional's Report for Injury at Work and Functional Abilities Form (attached). **Submit the completed forms along with the receipt or invoice for the cost to complete the forms directly to Acclaim Ability Management via fax at 1-866-486-8663.**
    - Employees will be reimbursed from Acclaim Ability Management for the cost to complete the forms.
- Actively participate in the Injury at Work process which includes: maintaining contact with Acclaim Ability Management, actively participate in treatment plans, work with Acclaim and Christian Horizons regarding the return to work process and work within the limitations/restrictions of the return to work plan, participate in the accident investigation.
- Review Christian Horizons' Policy for Injury at Work, including the Role of the Employee with the Disability.

Supervisor Responsibilities:

- Provide the employee with access to immediate medical attention (ambulance, taxi if necessary).
- Ensure the employee understands Christian Horizons' Injury at Work Policy, the required timelines and takes this package to their health care provider (licensed physician) to complete.
- Immediately offer the employee modified hours and/or duties if appropriate. Please consult with your Supervisor, the Abilities Specialist or the HRM (as needed).
- Inform the next level Supervisor of the injury at work and complete the P-5:2 Accident Investigation Report.
- Send both the P-5:1 Employee Accident/Occupational/Illness Report and the P-5:2 Accident Investigation Report to: accidentreports@christian-horizons.org and to your District office within 24 hours of completion.
    - NOTE: P-5:1 Employee Accident/Occupational/Illness Report must be completed within 24 hours of the incident and P-5:2 Accident Investigation Report must be completed immediately after the incident.
- Send a P-9:9b to HR Admin and Abilities Specialist if employee misses any shifts following the accident/incident.
- Follow the Care Management Report(s) provided by Acclaim Ability Management and submit P-9:9b to HR Admin and Abilities Specialist when the employee's status changes.
- Work with Acclaim, Abilities Specialist and the employee to facilitate a safe and timely return to work as soon as appropriate; create the Return to Work Plan in participation with employee.

Acclaim's Responsibilities:

- Receive and review all medical information and provide a decision regarding the claim.
- Contact the employee via telephone and in writing, keeping them informed of the status of their claim.
- Provide Care Management Reports to the Supervisor, Area Manager and Abilities Specialist; including return to work information or functional abilities.
    - Receive treatment information for paramedical expenses. Approve and process payment.

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Health Professional's Report for Injury at Work

CONFIDENTIAL

Christian Horizons has an internal insurance plan that provides specific support for employees that have been injured at work. Christian Horizons does not subscribe to WSIB insurance. Health Care Providers will be compensated for the completion of the enclosed forms by Acclaim Ability Management Inc using WSIB guidelines.

SECTION A: TO BE COMPLETED BY EMPLOYEE

Employee's Name____ Sex: M ___ F____

(Last name first, in full)

AUTHORIZATION

By signing below, I hereby authorize heath care provider(s) or institutions involved in my treatment to provide all information and documents requested by Acclaim Ability Management Inc. including LTD Carrier and Disability Management Consultants, concerning my medical or behavioral health condition. This authorization is valid from the date hereof through the date of return to work to full duty. All information will be treated in a highly confidential manner. Information regarding my restrictions/limitations will be shared with my supervisors. I agree that facsimile copy or a Photostat copy is to be considered effective as an original signed copy.

______________________________ ______________________________ ______________________________

Employee Name (Printed) Employee Signature Date

SECTION B: HEALTH PROFESSIONAL'S INFORMATION

Physician's name (please print): ______________________________ Speciality: ______________________________

Address: ____

Telephone: ______________________________ Fax: ______________________________

SECTION C: INCIDENT DATES AND DETAILS

1. Are you this patient's primary Health Professional: ☐ Yes ☐ No
2. Have you treated this patient in the past for this injury? ☐ Yes ☐ No

   If yes, please list dates of treatment since your last report below:

   ____
3. What is your understanding of how this injury or re-injury occurred? ☐ Yes ☐ No
4. Is this injury work related? ☐ Yes ☐ No

Date of Accident	dd	mm	yyyy
Date of Assessment	dd	mm	yyyy
Location of Assessment	☐Emergency ☐Walk-in-clinic ☐Other ______________	☐Office ☐Workplace	

5. Area of Injury, check all that apply:

Location	Body Part				Injury
☐ right	☐head	☐ arm	leg	☐ hip	☐ strain
☐ left	☐ face	☐ shoulder	☐ calf	☐ back	☐ abrasion
☐ upper	☐brain	☐elbow	☐ankle	☐ abdomen	☐ sprain
☐ lower	☐ eyes	☐ forearm	☐ thigh	☐ chest	☐ fracture
☐n/a		☐ finger	☐knee		☐ bruise
		☐ hand	☐ heel		☐ laceration
☐ ears		☐ wrist	☐foot		☐burn
☐ teeth			☐ toe		☐ puncture
☐ neck	☐ other specify:				☐ pull
☐ chest					☐tear
					☐ other specify:

Please fax completed form and invoice directly to ***ACCLAIM Ability Management*** at **1-866-486-8663** or e-mail it to faxes@acclaimability.com.

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ChristianHorizons

Health Professional's Report for Injury at Work
CONFIDENTIAL

6. Patient's Present Complaints (subjective complaints):

____

7. Physical Examination (objective findings):

____

8. Are there abnormal signs for any of the following:

Active ROM Passive ROM Gait
Strength Sensation Reflexes Other

If so, please describe:

____

9. Are you aware of any pre-existing or other conditions that may delay recovery? □ Yes □ No

10. Diagnosis/ Working Diagnosis:

____

____

SECTION D: TREATMENT PLAN AND RETURN TO WORK INFORMATION

1. Treatment Plan
Provide your proposed treatment plan for this patient
(Include goals, duration, frequency, etc.)

2. Medication(s) Prescribed
Provide prescription details and anticipated medication
Adverse effects that could possibly impact ability to Return to Work.

3. Assistive Devices Prescribed
Provide details (crutches, orthotic supports, etc.)

Treatment Plan/ Medication Details:

____

____

____

4. Investigation and Referrals:

☐ None ☐ Labs ☐ X-Rays ☐ MRI ☐ CT Scan ☐ EMG/NCS ☐ Other

☐ Family Physician ☐ Specialist Name: ____

☐ Chiropractor ☐ Massage Therapist ☐ Occupational Health Centre

☐ Physiotherapist ☐ Occupational Therapist ☐ Other: ____________________

Name of Referral/Facility (if known):__________________________Telephone: ________________Appointment Date: __________________

5. Return to work information Have you discussed return to work with your patient? □ Yes □ No

Return to work to modified duties Date:_______________

Return to work to full duties Date: ___________________ Date of next Assessment: ____

I hereby declare that the information being submitted is true and complete.

Physician's name (please print): ____

Signature: ____ Date: ____

Please fax completed form and invoice directly to ***ACCLAIM Ability Management*** at **1-866-486-8663** or e-mail it to faxes@acclaimability.com**.**

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ChristianHorizons

Functional Abilities Form (FAF) for Safe & Timely Return to Work
Injury at Work for Employees with Full-Time OR Part-Time permanent contracts

TO BE COMPLETED BY EMPLOYEE

Employee Name ______________________ Day Phone # (s) ______________________

Job Title ______________________ Work Location ______________________

AUTHORIZATION FOR RELEASE OF INFORMATION

By signing below, I hereby authorize heath care provider(s) or institutions involved in my treatment to provide all information and documents requested by Acclaim Ability Management Inc. including LTD Carrier and Disability Management Consultants, concerning my medical or behavioural health condition. This authorization is valid from the date hereof through the date of return to work to full duty. All information will be treated in a highly confidential manner. Information regarding my restrictions/limitations will be shared with my supervisors. I agree that facsimile copy or a Photostat copy is to be considered effective as an original signed copy.

I understand that Modified work is available immediately. If return to modified duties is indicated, I am to report to work for my next scheduled shift with this completed form in hand.

Next Scheduled Shift Date(s): | | | | | | **Number of Contract Hours per Week:** ______________

______________________ ______________________ ______________________
Employee Name (Printed) Employee Signature Date

TO BE COMPLETED BY LICENCED PHYSICIAN

Please indicate the Patient's Status and Task Limitations in relation to the Health Professional's Report.

- ☐ No Limitations = No Lost Time & Return to Work (Complete Health Professional's Information Section Below)
- ☐ Limitations As Specified = Return to Modified Duties (Complete Capabilities and Health Professional's Section Below and Health Professional's Report)
- ☐ Lost Time = No Return to Work (Complete Capabilities and Health Professional's Section Below and Health Professional's Report)

CAPABILITIES (Please complete this section even if NO return to work is recommend):

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 ______________
Pushing:	☐ up to 20 lbs;	☐ up to 30 lbs	☐ up to 40 lbs;	☐ no restriction;	☐ Other ______________
Pulling:	☐ up to 20 lbs;	☐ up to 30 lbs	☐ up to 40 lbs;	☐ no restriction;	☐ Other ______________
Bending	☐ up to 4 times/day	☐ up to 8 times/day	☐ no restriction;	☐ Other ______________	
Twisting	☐ up to 4 times/day	☐ up to 8 times/day	☐ no restriction;	☐ Other ______________	
Stair climbing:	☐ unable;	☐ 2-3 steps only;	☐ own pace;	☐ assisted;	☐ no restriction
Patient 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

Able to perform Cardiopulmonary Resuscitation (CPR)? ☐ Yes ☐ No

Able to perform Physical Restraint techniques? ☐ Yes ☐ No

Able to work alone ☐ Yes ☐ No

Hours per day: ☐ 4 hours; ☐ 6 hours; ☐ 8 hours; ☐ no restriction; ☐ less then 4 hours (specify) __________

Explanation/Barriers to Return to Work/Additional Details: ____

____

These limitations will apply for:_____(# of days/ weeks) Full duties date:______________ Follow up appointment date: __________ or none required ☐☐

Have you discussed return to work with above limitations with your patient? ☐Yes ☐ No

By completing this Functional Abilities Form, the information contained herein will become part of the employee health file and may be accessed by the patient, the LTD Insurance carrier, third party administrator, or other health care professionals, as applicable.

HEALTH PROFESSIONAL'S INFORMATION SECTION:

Physicians name (please print): ______________________ Speciality: ______________________

Address: ______________________________________ Telephone: ______________________

Fax: ______________ Signature: ______________________ Date: ______________________

Please fax completed form and invoice directly to ***ACCLAIM Ability Management*** at 1-866-486-8663 or e-mail it to faxes@acclaimability.com with Health Professional's Report.

ACCIDENT/INCIDENT/OCCUPATIONAL ILLNESS/ NEAR MISS REPORT

ChristianHorizons

This form must be submitted within 24 hours of the incident.
This form is to be completed by the employee immediately after an incident *(please print using black ink and print clearly if handwritten)*

Last Name: First Name:
Employee #: Position:
Program Name and #:
Date Of Accident: Time (2400):
Date Reported to Supervisor: Time (2400):
Was a person supported involved? ☐ Yes ☐ No
Location of Incident: Did the incident/injury occur during the application of restraints? ☐ Yes ☐ No
Witnesses (people present at time of accident):

State the incident including sequence of events leading up to the Incident:

TYPE OF INCIDENT
- ☐ Struck By or Contact With
- ☐ Caught In/On or Between
- ☐ Fall/Slip
- ☐ Over Exertion/Strain
- ☐ Exposure/Environmental
- ☐ Occupational Illness
- ☐ Sharps/Needle Stick
- ☐ Fire/Explosion
- ☐ Violence/Assault
- ☐ Motor Vehicle Accident
- ☐ Near Miss*
- ☐ Other: ______

*If you are reporting a near miss, was it due to: ☐ Unsafe Act ☐ Unsafe Condition ☐ Unsafe Equipment

Indicate type of injury, part of body involved and specify right or left side (below):

INJURY TO: (L= Left / R= Right)	**L**	**R**
☐ Face or Head	☐	☐
☐ Eye/Ear	☐	☐
☐ Upper Back	☐	☐
☐ Lower Back	☐	☐
☐ Neck / Shoulder	☐	☐
☐ Arm / Wrist	☐	☐
☐ Hand / Fingers	☐	☐
☐ Leg	☐	☐
☐ Toe / Foot	☐	☐
☐ Abdomen	☐	☐
☐ Chest	☐	☐
☐ Other: ______	☐	☐

TYPE OF INJURY:
- ☐ Laceration
- ☐ Strain / Sprain
- ☐ Bruise(s)
- ☐ Fracture
- ☐ Puncture
- ☐ Abrasion
- ☐ Amputation
- ☐ Burns
- ☐ Foreign Body
- ☐ Skin
- ☐ Exposure
- ☐ Other: ______

TREATMENT *(Must choose one)*:
- ☐ On-site First Aid Only
- ☐ Hospital Emergency Dept.
- ☐ Doctor's or Other Professional Care
- ☐ None

CLAIM TYPE *(Must choose one)*:
- ☐ Lost Time From Work (missed next shift)**
- ☐ No Lost Time From Work (did not miss next shift)
- ☐ Near Miss*
- ☐ Critical Injury **- Reported to Ministry of Labour**

Have you had a similar injury or disability? ☐ Yes ☐ No If yes, explain:
**If you lost time, when did you leave work? Date: Time (2400):
(Injury at Work – IAW package must be completed for lost time claims)

Please provide recommendations to prevent recurrence:

Employee Signature: ______________________ Date: ______________

Supervisor's Signature: ______________________ Date: ______________

DISTRIBUTION: Forward to the appropriate locations within 24 hours
1. Email: accidentreports@christian-horizons.org
2. Immediate Supervisor
3. District Office/Waterloo Office Supervisor
4. Health and Safety Representative/Joint Health & Safety Committee