SHORT TERM MEDICAL LEAVE (STML) & WORK ACCOMMODATION PACKAGE

FOR EMPLOYEES WITH FULL-TIME OR PART-TIME CONTRACTS; (PERMANENT AND TEMPORARY)

Employee Responsibilities:

- Work with your treating physician to complete the Attending Physician Statement (attached) for all non-work related absences or accommodation due to illness or injury when:
  - There is an absence of 10 or more calendar days, or
  - The employee is out of Personal Emergency Leave time and is off for 4 or more consecutive shifts
  - A workplace accommodation requiring significant adjustment to duties and/or hours is required (e.g. unable to lift).
- Submit the completed Attending Physician Statement to Acclaim Ability Management via fax (1-866-486-8663).
- Actively participate in the medical leave of absence process including the return to work process.
- Review Christian Horizons' Policy for Short Term Medical Leave including the Role of the Employee with the Disability.

Supervisor Responsibilities:

- Send a P-9:9(b) to HR Admin and copy medicalleaves@christian-horizons.org as soon as you are aware of any of the following situations:
  - An employee will be off due to a non-work related illness/injury for more than 10 calendar days, e.g., surgery requiring a 4-week recovery period;
  - An employee who has been off due to a non-work related illness/injury and their leave goes beyond 10 calendar days;
  - An employee has taken all their Personal Emergency Leave (PEL) time available but has time in their STML bank and is requesting pay for any Short Term Medical Leave of 4 consecutive shifts or more, due to illness/injury;
  - An employee who requests a workplace accommodation that requires significant adjustment to duties and/or hours (e.g. unable to lift).
- Ensure the employee understands Christian Horizons' Short Term Medical Leave Policy, the required timelines and has a copy of the short term medical leave and work accommodation package.
- Follow the Care Management Report(s) provided by Acclaim Ability Management and submit P-9:9b to HR Admin and medicalleaves@christian-horizons.org when the employee's status changes.
- Work with Acclaim and the employee to facilitate a safe and timely return to work and/or workplace accommodation; create the plan in participation with employee. Please consult with your Supervisor, the Abilities Specialist or the HRM (as needed).
- When necessary, prepare a Physical Demands Analysis Form for Acclaim to assist in understanding the employee's specific job duties.
- Maintain contact with the employee while the employee is off work.

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.

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Attending Physician Statement (APS)
For Short Term Medical (STM) and/or Work Accommodation

In order to support a Short Term Medical and/or a Work Accommodation for this employee and to facilitate his/her return to work we require specific information. Christian Horizons' is committed to providing a transitional/modified work program for its personnel and we require your guidance to ensure a timely and safe return to work. ACCLAIM Ability Management Inc. and Christian Horizons co-ordinate these efforts in collaboration with the primary care provider, manager/supervisor and worker. ***All costs associated with the completion of this form are the responsibility of the employee.***

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 ☐

AUTHORIZATION

I do, hereby authorize _____ (healthcare provider, licensed physician, medical practitioner, hospital, clinic) to disclose my medical and health information to ACCLAIM Ability Management Inc, which includes any independent evaluators, agents and consultants acting on behalf of ACCLAIM.

This consent pertains to my current absence from work and/or my need for modified or accommodated work, and/or the current referral to ACCLAIM Ability Management Inc for services. These services may include the results of consultations or assessments obtained regarding my health condition. I authorize ACCLAIM Ability Management Inc to release information to Christian Horizons' LTD carrier and/or other involved health care practitioners.

I understand that the aforementioned communication and information, portions thereof, and/or resulting recommendations that relate to my abilities or limitations to perform my job duties (excluding specific reference to diagnosis or related personal information) may be communicated to Christian Horizons for the purposes of any one or more of the following:

1. Accommodating for my health condition with Christian Horizons;
2. Providing information for modified work with Christian Horizons;
3. Validating or authorizing an absence from work;
4. Determining my eligibility for benefits; and/or
5. Managing my return to work with the Christian Horizons

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 may affect my eligibility for benefits through the Christian Horizons' Short Term Disability Benefits plan.

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 Christian Horizons has been formally severed, whichever is earlier. It may be withdrawn at any time if I provide prior written notification to ACCLAIM or to Christian Horizons.

_____	_____	_____
Employee Name (Printed)	Employee Signature	Date

SECTION A: ILLNESS / INJURY INFORMATION (To be completed by licensed Physician)

Nature of the Illness/Injury: _____

Date Illness/Injury Began: _____ Date of Examination by Physician: _____

Is this Illness/Injury work related: ☐ Yes ☐ No

Anticipated Length of Illness/Injury: _____ Date Patient Expected to Return to Full Duties: _____

Has a Follow Up Appointment been Scheduled: ☐ Yes ☐ No If ***yes***, when: _____

Has a Treatment Plan been Prescribed to the Patient: ☐ Yes ☐ No
If ***no***, please explain why: _____

Is the Patient Compliant with treatment: ☐ Yes ☐ No

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

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If the Patient cannot Return to Full Duties, can they Return to Work on Modified Duties: ☐ Yes ☐ No
If ***no***, please explain the medical contraindications: _____

SECTION B: CAPABILITIES INFORMATION (To be completed by licensed Physician even if NO return to work is recommended)

FUNCTIONAL ABILITIES:

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)

COGNITIVE ABILITIES:

COGNITIVE RESTRICTIONS AND LIMITATIONS

Sustain Concentration:	☐ No Limitation	☐ Specify details:
Interact with Others:	☐ No Limitation	☐ Specify details:
Process Instructions:	☐ No Limitation	☐ Specify details:
Driving:	☐ No Limitations	☐ Specify details:
Restrictions due to medication:	☐ None	☐ Specify details:

Additional Comments/Accommodations Required:

SECTION C: ATTENDING PHYSICIAN'S INFORMATION

Physicians name (please print): _____ Speciality: _____

Address: _____

Telephone: _____ Fax: _____

Signature: _____ Date: _____

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