Memo to Employees absent or requiring Accommodation due to Non-Occupational Injuries/Illness

If your injury occurred at work, please discontinue using this package and instead use the Injury at Work package

You make an essential contribution to the Company's success through your daily work. When you are absent, or require accommodation, your manager has to make adjustments in work assignments. As a result, any information your physician can provide as to your eventual return to work, either full- time, part-time, or with restrictions during recovery, will be very useful.

If you require workplace accommodation, have been absent from work for 10 or more calendar days, or have exhausted your Personal Emergency Leave and miss 4 or more consecutive shifts, please continue using this package. Otherwise, please contact your manager for further information and next steps.

To be eligible for benefits under the Disability plans, you must comply with the following conditions, failure to do so may result in suspension of your claim.

Medical reports:

a) COMPLETE the first section of the attached ATTENDING PHYSICIAN'S STATEMENT before submitting it to your treating physician or specialist.

b) Have your treating physician or specialist fill out the second section of the ATTENDING PHYSICIAN'S STATEMENT.

c) To submit the completed and signed ATTENDING PHYSICIAN'S STATEMENT Form, please send via confidential fax at 1-888-429-1747 or by email at disabilitymanagement@homewoodhealth.com You may also ask your physician or specialist to do so on your behalf.

Medical treatment:

a) You must receive appropriate MEDICAL treatment during your absence or work accommodation.

b) Initial treatment should be provided by a qualified medical practitioner. Treatment by a health care Practitioner other than a physician - a chiropractor or psychologist, for example - is acceptable on the condition that a diagnosis has first been made by a qualified medical practitioner and that the nature and duration of the treatment have been specified by this physician.

Homewood Health:

a) During your absence or work accommodation, Homewood Health may contact your treating physician or specialist, or may contact you, to obtain additional information on your medical condition, treatments and stage of recovery.

b) During your absence or work accommodation, Homewood Health may ask you to see a designated consulting physician to confirm a diagnosis, prescribed treatment, estimated length of absence or restrictions. Failure to attend or to co-operate with the exam without a valid reason may result in suspension of your claim.

Confidentiality:

All personal health information such as the diagnosis/medical condition is confidential. Only information such as the expected return to work date/work restrictions are provided to Karis Disability Services by Homewood Health.

Employee and Family Assistance Program (EFAP)

Short-term counselling services are available on a confidential, voluntary basis to Karis Disability Services employees experiencing personal difficulties.

This complimentary service can be reached through Homewood Health by calling 800-663-1142, 888-384-1152 (TTY) or 604-689- 1717 (collect). You can also visit the website at HomeWeb.ca

Communication:

If you plan on travelling or residing elsewhere than your primary residence during your medical absence or work accommodation, you must notify your supervisor at least one week in advance. Your supervisor will then inform the appropriate Abilities Team member, and medical advice will be sought from Homewood Health.

Responsibility:

a) You should follow the advice of your treating physician and/or Homewood Health and take steps to ensure a quick and complete recovery.

b) Performing activities that are incompatible with your disability or working at other employment may result in the suspension of your claim.

c) You are responsible in meeting with your treating physician on a monthly/regular basis to update your medical status and discuss health related concerns associated with a successful return to work.

d) All treatment plans recommended by the treating physician must be adhered to. Failure to do so may result in a suspension of your claim.

e) Ongoing communication between you and Homewood Health is fundamental in expediting a successful recovery and a smooth transition back into the workforce.

Light or modified duties:

If you are medically approved to perform light or modified duties, your manager / supervisor will thoroughly review accommodation options and accommodate your return depending on the availability of light or modified duties.

Cost of completion of forms:

All costs associated with the completion of the initial medical form related to your Medical Leave or work accommodation claim are your responsibility.

Short Term Disability Attending Physician's Statement and Employee Authorization

Employee Information and Consent to Be Completed by the Employee (Please print)		
Name: (Last, First, Middle Initial)	Name of your Employer: Karis Disability Management	
Primary Contact Number: (+ Area Code) ☐ Home ☐ Cell	Okay to leave a voice message? ☐ Yes ☐ No	Your pronoun: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other
Address: (Street, City, Province, Postal Code)		
Email Address:	Job Title:	Preferred Language: ☐ English ☐ French
Date of Birth: (mm/dd/yyyy)	Last Day at Work:	First Day of Missed Work:

Employee's Authorization for Release of Information

I authorize Homewood Health Inc. (HHI) to collect, use and disclose information and documents pertaining to my Short-Term Disability (STD) case with my physician(s) or other health care providers involved in my care, for the purpose of determining my eligibility for benefits under my employer's STD plan, and managing my medically supported absence. I also authorize HHI to share my personal information with physicians, treatment providers, service providers or medical and para-medical professionals for the purpose of facilitating optimal care and for planning and managing my return to work. I agree that HHI can share information about me with other insurers or benefit providers for the purpose of coordinating policies, confirming payor, and determining eligibility for benefits.

I further authorize HHI to provide all related medical information to the insurance carrier should I need to apply for Long Term Disability (LTD) benefits, for the purpose of assisting with the application process. I understand that information relating to my functional abilities, ability to work and ongoing entitlement to STD benefits will be shared with my employer; **no medical information will be shared with my employer**. All information will be handled in accordance with applicable Privacy Legislation.

I agree that my consent is valid for the duration of my claim and during a file audit. I understand that I can revoke this consent at any time, but that without it my claim may not be assessed and HHI's ability to assist with my recovery and return to work may be impeded. I agree that a photocopy of this authorization or electronic version is as valid as the original.

NOTE: in cases where safety or risk of life to yourself or others is a concern, HHI is required to take responsible action. This may mean notification to a spouse, physician or other authorities. If you are working in a Safety Sensitive Position, this will also mean notification to your employer and/or union. The reason for this is to assist in reducing the risk of harm to yourself, your co-workers and the public in general.

Employee Signature: _____ Date: _____

****Any fee required for completion of this form is the responsibility of the patient****

For assistance with this form, please contact Homewood Health Inc. at disabilitymanagement@homewoodhealth.com

Homewood Health
Experience the power of care

karis Disability Services

Dear Attending Physician

Your patient's employer is interested in supporting ill and injured employees in their recovery and ensuring a safe, timely return to work. Homewood Health Inc. has been retained by the employer to review your patient's absence to adjudicate their eligibility for STD benefits to determine when the patient is able to return to work. The information you provide will be used to assist with planning and managing an early and safe return to work. Your assistance is greatly appreciated.

To Be Completed by the Physician (Please Print)

Patient Name:	Date of Birth: (mm/dd/yyyy)

Nature of Illness – Please select appropriate ICD-10 Diagnostic Category:

☐	A00-B99	Certain infectious and parasitic diseases	☐	C00-D49	Neoplasms
☐	D50-D89	Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism	☐	E00-E89	Endocrine, nutritional, and metabolic diseases
☐	F01-F99	Mental, Behavioral and Neurodevelopmental disorders	☐	G00-G99	Diseases of the nervous system
☐	H00-H59	Diseases of the eye and adnexa	☐	I00-I99	Diseases of the circulatory system
☐	J00-J99	Diseases of the respiratory system	☐	K00-K95	Diseases of the digestive system
☐	L00-L99	Diseases of the skin and subcutaneous tissue	☐	M00-M99	Diseases of the musculoskeletal system and connective tissue
☐	N00-N99	Diseases of the genitourinary system	☐	O00-O9A	Pregnancy, childbirth, and the puerperium
☐	Q00-Q99	Congenital malformations, deformations, and chromosomal abnormalities	☐	R00-R99	Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified
☐	S00-T88	Injury, poisoning, and certain other consequences of external causes			

Primary Diagnosis:

Secondary Diagnosis and/or Complications, which may be impacting your patient's level of function or the expected recovery period:

Date of first visit to you for this absence:	First date of work absence due to this condition:	Date of next appointment with you:

Has the patient been treated for this same or similar condition in the past? ☐ Yes ☐ No
If yes, date:

Related to Motor Vehicle Accident? ☐ Yes ☐ No

Hospitalization Is/Was patient hospitalized: ☐ Yes ☐ No

Date of Admittance: Date of Discharge:

If absence is related to childbirth, expected or actual delivery date:

Surgery If surgery was performed, please provide:

Date: Description: Usual recovery time for surgical procedure:

Treatment (Medication, Dosage, Physiotherapy, Other):

Is the patient following the recommended treatment program? ☐ Yes ☐ No

Estimated date for return to full duties and hours of work:

*"The CMA recognizes the **importance of a patient returning to all possible functional activities relevant to his or her life as soon as possible after an injury or illness**. Prolonged absence from one's normal roles, including absence from the workplace, is detrimental to a person's mental, physical and social well-being. A safe and timely return to work benefits the patient/employee and his or her family by enhancing recovery and reducing disability." --- 2013 Canadian Medical Association Policy Statement*

Homewood Health subscribes to the benefits of early and safe return to work; your responses to the questions below will assist in making recommendations to your patient's employer regarding possible accommodations that could limit the time away from work.

Please describe your patient's functional ability - tasks and activities your patient **can perform** (e.g.: prepare meals, manage finances, operate a vehicle, regular exercise program, etc.). This will be used to assist in determining possible accommodations.

Based your clinical findings and observations, please describe your patient's current cognitive and/or physical **restrictions and limitations** (e.g.: no lifting greater than 10 lbs, no prolonged sitting, unable to multi-task, unable to perform tasks that require tight deadlines, etc.)

Please indicate how long these restrictions and limitations should be in place:

Considering your patient's restrictions and limitations, would they be able to work in a different setting? ☐ Yes ☐ No

If no, please explain:

Please indicate the date your patient should be ready to return to some form of work, bearing in mind that restrictions or limitations could be accommodated:

Please indicate if your patient has or will be seen by a specialist for this condition: ☐ Yes ☐ No

Name of Specialist:	Specialty:	Date of Visit:

Attending Physician's acknowledgement

I acknowledge that the information in this statement will be kept in the patient's file with Homewood Health Inc. and may be disclosed to the patient and/or those authorized by him/her unless I (the physician) notify you in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the patient or in harm to a third party.

Name of Attending Physician: (please print)	Physician's Specialty:	Telephone Number:
Address:		Fax Number:
Signature:		Date:

****Any fee required for completion of this form is the responsibility of the patient****

Please send the completed form to Homewood Health via confidential fax at 1-888-429-1747 or by email at disabilitymanagement@homewoodhealth.com