Attending Physician Form

For absences greater than 5 days

Send completed form to confidential fax 403-342-3303

TO BE COMPLETED BY EMPLOYEE

Name:	ID:	Date of birth:
Job position:	Faculty/Dept:	
Home phone #:	Personal email address:	
First day off work:	Is this an: ☐ Illness ☐ Injury	Is this work related: ☐ Yes ☐ No

This information is being collected under the authority of Section 33(c) of the Alberta *Freedom of Information and Protection of Privacy* Act (FOIP), will be used for the purpose(s) of payroll and benefit administration and is protected by the privacy provisions of FOIP.

If you require further information regarding the collection and use of this information, contact Health,Safety and Wellness at (403) 342-3427. *You will be reimbursed for any physician fee for the completion of this form once you have submitted your invoice to HSW.*

Employee signature: Date:

DEAR PHYSICIAN

Your patient is an employee of the Red Deer College who is currently absent from work due to a non-occupational illness or injury. Red Deer College provides modified work to meet the temporary and permanent accommodation needs of our employees. RDC Health, Safety and Wellness provides services to support the employee back to safe and meaningful work as soon as medically suitable and preserve confidentiality of medical information. *Please bill your patient directly for the completion of this form (they will be reimbursed in accordance with the Colleges expense reimbursement procedures).Thank you for your cooperation.*

TO BE COMPLETED BY PHYSICIAN (please print clearly in all applicable areas)

Is this health issue: ☐Work related ☐Non-occupational ☐Conflict in the Workplace

Date of illness began or onset of symptoms:	Date of first visit for this absence:	First date of work absence due to this condition:

Primary nature of illness / disability:

Do co-morbid conditions exist: ☐ Yes ☐ No

Severity: ☐ Mild ☐ Moderate ☐ Severe

Is the condition: ☐ Improving ☐ Unchanged ☐ Deteriorating

Prognosis:

Has active treatment plan been prescribed: ☐ Yes ☐ No

Is the patient compliant with treatment plan: ☐ Yes ☐ No

Is the patient:

☐ Fit to return to work to own job

☐ Fit to return to work with limitations or fit for modified / alternate work with limitations identified below

☐ Unfit for even modified / alternate duties

Please outline clinical or objective medical information that support the above:

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Please indicate the current physical work abilities or limitations:			
	Able	**Unable**	**Limited to:**
Lifting Floor to Waist			Max_____ lbs ☐ Frequently ☐ Occasionally
Lifting Waist to Shoulder			Max_____ lbs ☐ Frequently ☐ Occasionally
Lifting Above Shoulder			Max_____ lbs ☐ Frequently ☐ Occasionally
Pushing/Pulling			Max force:____ lbs ☐ Frequently ☐ Occasionally
Reaching Above Shoulder			☐ Left ☐ Right ☐ Frequently ☐ Occasionally
Reaching Below Shoulder			☐ Left ☐ Right ☐ Frequently ☐ Occasionally
Use of Hands			☐ Left ☐ Right ☐ Frequently ☐ Occasionally
Standing			_____ mins ☐ At a time ☐ Cumulative
Walking			_____ mins ☐ At a time ☐ Cumulative
Sitting			_____ mins ☐ At a time ☐ Cumulative
Bending			☐ Frequently ☐ Occasionally
Twisting			☐ Frequently ☐ Occasionally
Squatting/Kneeling			☐ Frequently ☐ Occasionally
Climbing			☐ Frequently ☐ Occasionally
Additional comments to the above work abilities:			

Please indicate the current cognitive work abilities or limitations:			
	No Impact	**Decreased Capacity**	**Comments**
Concentration / Focus			
Memory			
Energy / Alertness			
Social Interactions			
Comprehension / Communication			
Decision Making / Judgement			
Additional comments to the above work abilities:			

Will the patient require time off during the return to work plan to attend treatment plan appointments: ☐ Yes ☐ No
If yes, provide details:

Is complete recovery expected:	Estimated Return to Work Date(s)	
	Modified Hours/Duties:	Full Duties:
Yes ☐ No ☐ Unknown ☐		

Is a follow-up reassessment required? ☐ Yes ☐ No If yes, appointment date:

Physician's Name, Address, Phone and Fax Number:	Physician's Signature:
	Date: