Waypoint
CENTRE for MENTAL HEALTH CARE
CENTRE de SOINS de SANTÉ MENTALE

WAYPOINT APPLICATION FOR MEDICAL RESTRICTIONS OR MEDICAL LEAVE

Further to Waypoint's ***Short Term Sick Leave Policy & Procedure*** It is the responsibility of each staff member to provide valid medical documentation to support requests for Medical Restrictions or Medical Leave. Medical documentation must be submitted to **Occupational Health** by:

Email (preferred): ohn@waypointcentre.ca
Fax: 705-549-3750

Restriction Requests: Failure to provide supporting medical documentation may result in denial of the restriction request.

Medical Leaves: Failure to provide supporting medical documentation within the timelines outlined below may result in the leave being classified as unauthorized, and may result in interruption to sick benefits if applicable.

- After 5 consecutive days of absence (OPSEU Collective Agreement, Article 23.10)
- After 7 consecutive calendar days absence (AMAPCEO Collective Agreement, Article 37.8)
- After 5 working days of absence for all non-union, management and excluded employees

Important Notice: Employees are expected to provide complete, accurate, and truthful information in support of this application. Providing false, incomplete, or misleading information, or failing to disclose relevant information, may result in disciplinary action up to and including termination of employment.

*for any work related injury or illness, medical documentation is to be completed on a WSIB Form 8 or WSIB Functional Abilities Form (FAF)

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NAME OF EMPLOYEE: _____ **ASSESSMENT DATE:** _____

DATE OF BIRTH: _____

1. The patient was absent from work on the date(s): _____ due to:

   ☐ Personal injury ☐ Personal illness ☐ Psychological

2. Please describe the nature of the illness or injury (diagnosis not required)

   _____

3. In my opinion, supported by objective medical evidence, the following return to work status is appropriate:
   ☐ Patient is capable of returning to work with no restrictions
   ☐ Patient is capable of performing **modified work with restrictions** (complete sections A, B & C if applicable)
   ☐ Patient is **totally disabled from performing any modified work at this time** (complete sections A, B & C if applicable) **total disability means the inability to perform **any** form of work*

SECTION A: Functional Abilities

Physical Demand		**Current Ability**		**Comments**
		Max Tolerance (duration or weight)	**Frequency/Time (between tasks)**	
Sitting				
Standing				
Walking				
Weights		**Max Tolerance (duration or weight)**	**Frequency/Time (between tasks)**	**Comments**
Lifting	Floor to Waist			
	Waist to Shoulder			
	Above Shoulder			
Carrying				
Pushing				
Pulling				
Repetitive Motions		**Max Tolerance (duration or weight)**	**Frequency/Time (between tasks)**	**Comments**
Reaching	Below Waist			
	Waist to Shoulder			
	At or above Shoulder			
Bending and Twisting	Waist			
	Neck			
	Other – please specify			
Climbing	Stairs/Ladders			
Fine Motor (including typing/writing)				
Grasping				

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SECTION B: Cognitive Abilities

Cognitive Ability	No Restriction	Limited Capacity	Unable to Perform
Attention to detail, concentration, and memory	☐	☐	☐
Planning, organization, time management, deadline pressures	☐	☐	☐
Judgment, orientation, reasoning, and problem solving	☐	☐	☐
Confrontation, Working with others	☐	☐	☐
Responsibility and Accountability	☐	☐	☐
Comments (for any limitations noted above, please provide additional comments or clarify any inability as relates to work duties):			

SECTION C: Medical Recommendations

4. Please identify any medical restrictions or considerations that may impact scheduling, hours of work, duties, physical work environment, or other work arrangements, and provide clarification or rationale as needed.

5. Please indicate if the patient's tolerance is improving or deteriorating: _____
6. Are there workplace factors contributing to the Employee's medical condition? _____
7. a) Is the patient currently under active treatment for this condition NO YES Frequency: _____
   b) Is the patient following the treatment plan prescribed? NO YES
   c) What is the prognosis for improvement? _____
   d) Is a specialist referral required? NO YES
   e) If yes, has referral been made? NO YES
   f) Is the patient taking medication, which may impair their judgment or ability to work safely? NO YES
   g) If yes, please explain: _____
   h) Please provide any additional comments required_____

SECTION D: Follow Up and Return to Work

8. Date of follow-up assessment: _____
9. Anticipated date of return to work (if known) _____

_____
Health Professional Name and Designation (please print or stamp)

_____ _____
Health Professional Signature Date