OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

Employee Sick Leave Information and Instructions

1. If you have an illness/injury and require time off work please notify your Supervisor as per your regular absence reporting process. Injury or illness that resulted in the course of your employment must be reported to your supervisor for reporting to the WSIB.

2. If you are or will be absent for 6 days or more, or your short term absence is extended to 6 days or more please obtain a sick leave package from your supervisor.

3. Take the Abilities Form to your health care professional for completion. Please have your Health Care Professional (HCP) complete and return to Employee Wellness. Please be advised that appropriate sections must be completed by your HCP to support access to paid sick leave. If all sections are not complete this may delay access to approved paid sick leave.

4. Please ensure that you return the completed form to the Employee Wellness confidential fax **613-596-8798 or 613-596-8726** or with your consent your health care professional may fax it directly.

5. If you require assistance during your absence or with return to work planning please contact your Disability Management Coordinator as follows:

   Christine Marleau – DMC – 613-596-8211, ext. 8335
   (Employee last name A-K)

   Kim Benson – DMC – 613-596-8211, ext. 8270
   (Employee last name L-Z)

6. In some cases, your Disability Management Coordinator may call you to offer support during your absence.

7. Ottawa-Carleton District School Board will provide accommodations and transitional return to work options, if available, and if you require it, in order to assist in your return to work.

8. The Abilities Form may be requested throughout your absence dependent upon your individual circumstances.

9. The completed Abilities Form supports your absence due to illness / injury and access to paid sick leave entitlement.

10. If there is a fee associated with the completion of the Abilities Form , please submit proof of payment to Employee Wellness for reimbursement.

Attached: Abilities Form
Health Care Professional Letter

OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

Dear Health Care Professional:

The Ottawa-Carleton District School Board (OCDSB) is committed to assisting employees in their recovery and providing safe return to work. The OCDSB will provide transitional modified duties and/or modified hours of work, if required.

Employees must provide sufficient objective medical documentation to support their absence, to qualify for benefits, and to assist in the development of a return to work plan appropriate to the employee's abilities and limitations.

Attached is the OCDSB Abilities Form. Please be advised that appropriate sections must be completed. If all sections are not complete this may delay access to approved paid sick leave and result in a follow up request to you.

A Disability Management Coordinator from the OCDSB will work with your patient to support and help your patient during his/her recovery and return to work.

Confidentiality of medical information will be respected at all times. The employee's functional capabilities and / or restrictions will be shared with appropriate staff within the OCDSB.

We thank you in advance for your assistance and invite you to contact us at 613-596-8250 with any questions.

Sincerely,

Employee Wellness

Employee Wellness & Disability Management
613-596-8250

Attached: OCDSB Abilities Form

OTTAWA-CARLETON DISTRICT SCHOOL BOARD – ABILITIES FORM (2 pages)

Employee Group:	***Requested By:***
WSIB Claim: ☐ ***Yes*** ☐ ***No***	***WSIB Claim Number:***

To the Employee: The purpose for this form is to provide the Board with information to assess whether you are able to perform the essential duties of your position, and understand your restrictions and/or limitations to assess workplace accommodation if necessary.

Employee's Consent: I authorize the Health Professional involved with my treatment to provide to my employer this form when complete. This form contains information about any medical limitations/restrictions affecting my ability to return to work or perform my assigned duties.

Employee Name: *(Please print)*	**Employee Signature:**
Employee ID:	**Telephone No:**
Employee Address:	**Work Location:**

1. Health Care Professional: The following information should be completed by the Health Care Professional

Please check one:

☐ Patient is capable of returning to work with no restrictions.

☐ Patient is capable of returning to work with restrictions. **Complete section 2 (A & B) & 3**

☐ I have reviewed sections 2 (A & B) and have determined that the Patient is totally disabled and is unable to return to work at this time. **Complete sections 3 and 4. Should the absence continue, updated medical information will next be requested after the date of the follow up appointment indicated in section 4.**

First Day of Absence: _____	General Nature of Illness (***please do not include diagnosis***): _____

Date of Assessment:
dd mm yyyy

2A: Health Care Professional to complete. Please outline your patient's abilities and/or restrictions based on your objective medical findings.

PHYSICAL (if applicable)

Walking:	**Standing:**	**Sitting:**	**Lifting from floor to waist:**
☐ Full Abilities	☐ Full Abilities	☐ Full Abilities	☐ Full Abilities
☐ Up to 100 metres	☐ Up to 15 minutes	☐ Up to 30 minutes	☐ Up to 5 kilograms
☐ 100 - 200 metres	☐ 15 - 30 minutes	☐ 30 minutes - 1 hour	☐ 5 - 10 kilograms
☐ Other (*please specify*):	☐ Other (*please specify*):	☐ Other (*please specify*):	☐ Other (*please specify*):

Lifting from Waist to Shoulder:	**Stair Climbing:**	☐ **Use of hand(s):**	
☐ Full abilities	☐ Full abilities	**Left Hand**	**Right Hand**
☐ Up to 5 kilograms	☐ Up to 5 steps	☐ Gripping	☐ Gripping
☐ 5 - 10 kilograms	☐ 6 - 12 steps	☐ Pinching	☐ Pinching
☐ Other (*please specify*):	☐ Other (*please specify*):	☐ Other (*please specify*):	☐ Other (*please specify*):

☐ **Bending/twisting** repetitive movement of (*please specify*):	☐ **Work at or above shoulder activity**:	☐ **Chemical exposure to**:	**Travel to Work**: Ability to use public transit _____ Ability to drive car	☐ Yes ☐ No _____ ☐ Yes ☐ No

Ottawa-Carleton District School Board
133 Greenbank Road, Ottawa, K2H 6L3
FAX COMPLETED FORM TO: 613-596-8798 or 613-596-8726

OTTAWA-CARLETON DISTRICT SCHOOL BOARD – ABILITIES FORM (2 pages)

2B: COGNITIVE (*please complete all that is applicable*)			
Attention and Concentration: ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Following Directions:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Decision- Making/Supervision:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Multi-Tasking:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:
Ability to Organize: ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Memory:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Social Interaction:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Communication:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:

Please identify the assessment tool(s) used to determine the above abilities *(Examples: Lifting tests, grip strength tests, Anxiety Inventories, Self-Reporting, etc.*

Additional comments on **Limitations (not able to do) and/or Restrictions (<u>should/must</u> not do) for all medical conditions**:

3: Health Care Professional to complete.

From the date of this assessment, the above will apply for approximately:	Have you discussed return to work with your patient?
☐ 6-10 days ☐ 11- 15 days ☐ 16- 25 days ☐ 26 + days	☐ Yes ☐ No
Recommendations for work hours and start date (if applicable):	Start Date: **dd** **mm** **yyyy**
☐ Regular full time hours ☐ Modified hours ☐Graduated hours	

Is patient on an active treatment plan?: ☐ Yes ☐ No

Has a referral to another Health Care Professional been made?
☐ Yes (optional - please specify): _____ ☐ No

If a referral has been made, will you continue to be the patient's primary Health Care Provider? ☐ Yes ☐ No

4: Recommended date of next appointment to review Abilities and/or Restrictions: dd mm yyyy

Completing Health Care Professional Name: (Please Print)	
Date:	
Telephone Number:	
Fax Number:	
Signature:	

OSSTF – Central Agreement - 2015

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