ORGANIZATIONAL SOLUTIONS INC.
SOLUTIONS ORGANISATIONNELLES INC.

Commission Scolaire **Kativik** School Board

<u>ᐊᑯᓂᐅᖕᖏᑐᖅ ᐱᕐᖃᔭᕐᓯᒪᑫᓐᓇᓂᕐᒧᑦ ᒪᓕᒐᑦᓴᑦ</u>

1. ᐊᕐᖁᓇᕐᓯᒪᒍᕕᑦ ᖃᓂᒪᒍᕕᓪᓗᓃᑦ ᐱᓇᓱᒐᕐᓅᓕᖓᖕᖏᑐᒥᒃ ᐱᓇᓱᖕᖏᑫᓐᓇᕈᑎᒥᒥᐊᖃᕐᓯᒍ, ᖃᐅᔨᑎᑦᓯᔪᑦᓴᐅᕗᑎᑦ ᐊᖓᔪᕐᖄᓃᕕᑦ / ᑲᒪᔨᓐᓃᕕᑦ. ᑲᑎᕕᒃ ᐃᓕᓐᓂᐊᓂᓕᕆᓂᐅᑉ ᐱᓇᓱᑦᑐᓕᕆᔨᖕᒥᑦᑕ ᐱᓇᓱᑦᑎᖓ ᐅᖃᕈᑎᖃᕐᓂᐊᓕᕐᒪᑦ ᐱᓇᓱᖕᖏᑑᖃᑦᑕᓂᕐᓂᒃ ᐱᒍᑦᔨᔨᓄᑦ Organizational Solutions Inc.

2. ᐊᑯᓂᐅᖕᖏᑐᖅ ᐱᕐᖃᔭᕐᓯᒪᑫᓐᓇᓂᕐᒧᑦ ᐱᓇᓱᖕᖏᑫᓐᓇᕈᓐᓇᐅᑎᓂᒃ ᐱᓗᑎᑦ ᐱᓇᓱᑦᑐᓕᕆᕕᒻᒥᑦ ᐊᖓᔪᕐᖄᓃᕕᓪᓗᓃᑦ. ᐱᓇᓱᑦᑎᒧᑦ ᐊᓪᓚᕕᐅᒥᐊᓚᓐᓄᑦ ᐊᓪᓚᓗᑎᑦ ᐊᒻᒪᓗ ᐋᓐᓂᐊᓯᐅᕐᑎᒪᕆᒻᒧᑦ ᐊᓪᓚᕕᐅᒥᐊᓖᑦ ᐋᓐᓂᐊᓯᐅᕐᑎᒪᕆᓐᓅᕕᑦ ᐊᓪᓚᕕᐅᑎᒥᐊᕐᑐᓗᒥᑦ. ᐅᑎᕐᑎᓗᒥᑦ ᐅᓪᓗᐃᑦ 14 ᓈᓚᐅᕐᑎᓇᒥᑦ ᑐᖁᓐᓇᑎᓗᒥᑦ ᐱᒍᑦᔨᔨᓄᑦ OSI ᓱᑲᑦᑐᑰᕈᑎᒃᑯᑦ #: 1-866-511-0008 ᐊᑦᔨᓕᐅᕐᑐᒥᓪᓗᓃᑦ ᖃᓇᑕᐅᔭᒃᑯᑦ ᐊᐅᓪᓚᑐᑦᓴᓕᐊᓇᓗᒥᑦ ᑐᖀᕈᑎᒧᑦ kativikschoolboard@orgsoln.com.

3. ᐱᓇᓱᑦᑎᖓᓄᑦ ᐅᖄᓚᕕᐅᒐᔭᕐᑐᑎᑦ ᐃᑲᔪᕐᓯᒪᒍᓐᓇᓂᕋᕐᑐᓂ ᐱᓇᓱᖕᖏᑫᓐᓇᓂᕐᓂ ᐱᓇᓱᕝᕕᓄᑦ ᐅᑎᖕᖏᓂᕐᓂ.

4. ᑲᑎᕕᒃ ᐃᓕᓐᓂᐊᓂᓕᕆᓂᒃᑯᑦ ᐱᓇᓱᒐᑦᓴᓃᕕᑦ ᐱᓇᓱᒐᕐᓅᕕᑦ ᐅᑎᕐᐸᓕᐊᒍᑎᑦᓴᓃᕕᑦ ᐊᑐᐃᓐᓇᐅᑎᑦᓯᒪᔭᕐᑐᑦ ᐊᑐᐃᓐᓇᐅᐸᑕ, ᒥᐊᖃᕐᓂᕈᕕᓪᓗ, ᐱᓇᓱᕝᕕᓅᕕᑦ ᐅᑎᕐᐸᓕᐊᒍᑎᑦᓴᓃᕕᑦ ᐃᑲᔪᕐᓯᒪᒍᒪᒍᑦ. ᐱᓇᓱᕝᕕᓅᕕᑦ ᐅᑎᕐᐸᓕᐊᒍᑎᑦᓴᓂᒃ ᐱᒥᐊᖃᕈᕕᑦ, ᐋᓐᓂᐊᓯᐅᕐᑎᒪᕆᓐᓃᕕᑦ ᕿᓄᕕᖃᓇᐊᖃᕋᔭᕐᑐᑎᑦ ᖃᓄᓪᓗᐊᑎᒥᒃ ᐱᓇᓱᒍᓐᓇᒪᖔᕐᐱᑦ ᑐᑭᓯᒪᐅᑎᓂᒃ Functional Abilities Form (FAF).

5. ᒪᒥᓴᕐᓂᒦᓚᒫᓇᐊᖃᕐᑐᑎᑦ ᐱᓇᓱᒐᕐᓅᕕᑦ ᐅᑎᕈᓐᓇᓯᓈᑐᐊᕈᕕᑦ.

6. ᖃᒻᒥᓂᑕᑦᓯᐊᓂᒃ ᐋᓐᓂᐊᓯᐅᕐᑎᒪᕆᑉᐱᑦ ᐅᖃᐅᓯᑦᓴᕆᓯᒪᔭᖏᓐᓂᒃ ᐱᑕᖃᕆᐊᖃᕐᑐᑎᑦ ᑐᒃᓯᕋᕐᕕᐅᓕᕈᕕᑦ. ᐃᑲᔪᕐᓯᒍᑎᐅᒻᒪᑕ ᑲᑎᕕᒃ ᐃᓕᓐᓂᐊᓂᓕᕆᓂᕐᒥᒃ ᐊᒻᒪᓗ ᐱᒍᑦᔨᔨᓂᒃ Organizational Solutions Inc. ᐱᓇᓱᒐᕐᓅᓕᖓᕗᓂᒃ. ᐱᒍᑦᔨᔨᓄᑦ Organizational Solutions Inc. ᐃᑲᔪᕐᑕᐅᒍᓐᓇᑐᑎᑦ ᒪᒥᓴᕈᑎᑦᓴᑎᑦ ᐸᕐᓈᑕᐅᒥᐊᖃᓕᕐᐸᑕ ᖃᓄᐃᖕᖏᓯᐊᕐᐸᓕᐊᒍᑎᑦᓴᓃᕕᑦ.

7. ᐱᓇᓱᕝᕕᒧᑦ ᐅᑎᕐᑐᑎᑦ.

8. ᐱᒍᑦᔨᔩᑦ OSI ᐱᓇᓱᑦᑎᖓᓂᒃ ᖃᐅᔨᒥᐊᕐᕕᖃᕐᖄᕈᒪᒍᕕᑦ ᐅᖄᓚᕕᒥᒍᓐᓇᑌᑦ ᐅᕗᖓ 1-866-674-7656 ᐊᐱᕐᔫᑎᑦᓴᖃᕈᕕᑦ ᑭᐅᒍᓐᓇᒪᑦ.

ᐃᓚᖃᕐᒥᔪᑦ: ᐱᓇᓱᑦᑎᐅᑉ ᐊᓪᓚᑕᕕᓂᖕᒥᑦ
ᐋᓐᓂᐊᓯᐅᕐᑎᒪᕆᐅᑉ ᐊᓪᓚᓯᒪᔪᕐᑖᖕᒥᑦ
ᑲᒪᔪᕕᓂᐅᑉ ᐋᓐᓂᐊᓯᐅᕐᑎᒪᕆᐅᑉ ᐅᖃᐅᓯᑦᓴᖕᒥᑦ

ᐱᓇᓱᑦᑎᒧᑦ;

ᐱᑦᔪᑎᖓ: **ᐊᑯᓂᐅᙱᑐᖅ ᐱᖅᖃᔦᕐᓯᒪᑫᓐᓇᓂᕐᒧᑦ ᐱᓇᓱᙱᑫᓐᓇᕈᒪᐅᑏᑦ** (STD)

ᑲᑎᕕᒃ ᐃᓕᓐᓂᐊᓂᓕᕆᓂᖅ ᐱᒍᑦᔭᐅᓃᒍᕗᖅ ᐱᒍᑦᔨᔨᓪᓚᕆᐅᖃᑕᐅᔪᓄᑦ ᑲᒪᒋᔭᐅᒋᐊᓖᑦ ᐊᐅᓚᑕᐅᓂᖏᓐᓂᒃ Organizational Solutions Inc. (OSI) ᐊᑯᓂᐅᙱᑐᖅ ᐱᖅᖃᔦᕐᓯᒪᑫᓐᓇᓂᕐᒧᑦ ᐱᓇᓱᙱᑫᓐᓇᕈᒪᐅᑎᓕᓇᔨᓄᑦ. ᑖᒃᑯᓄᖓ ᐱᒍᑦᔭᐅᓃᒍᔪᒧᑦ ᓇᐅᓕᒫᓄᑦ ᑐᓴᐅᒪᔭᐅᒋᐊᖃᙱᑐᓂᒃ ᐱᒍᑦᔨᒋᐊᖃᓕᑐᐊᑫᑦᑕ ᐱᓇᓱᙱᑫᓇᑐᖃᓕᑐᐊᕐᒪᑦ.

ᖃᓂᒪᑐᐊᕈᐱᑦ ᐊᖅᑯᓇᕐᓯᒪᒍᐱᓪᓗᓃᑦ OSI ᐱᓇᓱᑦᑎᖏᓐᓄᑦ ᐃᑲᔪᕐᓯᔭᐅᒐᔭᕐᑐᑎᑦ ᒪᒥᓴᕐᓂ ᐱᓇᓱᕝᕕᓄᑦ ᐅᑎᓚᐅᕐᑎᓇᒃ. ᑲᒪᒍᓯᖃᕐᒥᔦᑦ ᐱᕕᑦᓴᖃᕐᑎᓯᑦᓯᑎᒃ ***"ᑲᒪᑦᓯᐊᓇᐊᖃᕐᓂᒥᒃ"* *"ᑲᒪᒋᔭᐅᒋᐊᖃᕐᑐᖃᕐᓂᖓᓂ"*, *ᑲᒪᒋᔭᐅᓯᒪᑦᓯᐊᓇᐊᖃᕐᓂᒥᓪᓗ*©**. ᑲᑎᕕᒃ ᐃᓕᓐᓂᐊᓂᓕᕆᓂᕐᒧᑦ ᐊᑐᐃᓐᓇᐅᑎᑕᐅᔦᑦ ᐱᓇᓱᑦᑎᓄᑦ ᐱᕕᑦᓴᖃᕐᑎᑕᐅᔦᓕᒫᓄᑦ.

ᐱᓇᓱᖅᖃᔦᕐᓯᒪᒍᐱᑦ ᐱᓇᓱᕝᕕᒥᐅᙱᑐᖅ ᐊᖅᑯᓇᕐᑐᐱᓂᐅᓂᕐᒧᑦ ᖃᓂᒪᑐᐱᓂᐅᒍᐱᓪᓗᓃᑦ, ᐊᓪᓚᓯᒪᔦᕐᑖᓇᐊᖃᕐᑐᑎᑦ (APS) ᐋᓐᓂᐊᓯᐅᕐᑎᒪᓇᒥᑦ ᑲᒪᔨᐱᓂᕐᓂᑦ. ᐋᓐᓂᐊᓯᐅᕐᑎᒪᓇᒧᑦ ᓱᓇᒥᑦᓯᐊᑐᓂᒃ ᐊᓪᓚᕕᐅᒥᐊᓕᒃ ᑖᓐᓇ ᐊᓪᓚᕕᑦᓴᖅ ᑐᕈᓐᓇᑐᒃᑯᑦ ᑐᓂᔭᐅᒥᓗᓂ ᐱᒍᑦᔨᔨᓄᑦ. ᑖᓐᓇ ᐊᓪᓚᕕᑦᓴᖅ ᓱᓇᒥᑦᓯᐊᓕᕐᑎᓗᒍ ᐱᒍᑦᔨᔨᓅᕐᑕᐅᓂᐊᓕᕐᒥᒪᑦ (OSI) **ᐅᓪᓗᐃᑦ 14** ᓈᓚᐅᕐᑎᓇᒥᑦ ᐱᓇᓱᙱᑑᓯᒋᐊᕐᑐᕕᓂᐅᑦᓯᑎᑦ; ᑌᒣᙱᑐᐊᕐᐸᑦ, ᐱᓇᓱᕝᕕᓯ ᖃᐅᔨᑎᑕᐅᓚᔭᕐᑐᖅ ᑌᒪ ᐱᕙᓪᓕᕐᑯᑎᑦ ᓄᖅᑲᙳᑎᑕᐅᑫᓐᓇᓂᐊᓕᕐᒪᑕ ᐋᓐᓂᐊᓯᐅᕐᑎᒪᓇᒥᑦ ᐱᓯᒪᔪᓂᒃ ᐊᓪᓚᑖᕐᑎᓯᓯᒪᙱᓂᕐᒧᑦ.

ᐃᓅᓐᓀᓄᑦ ᑐᑭᓯᒪᒐᑦᓴᑦ

"ᐱᖅᖃᔦᕐᓯᒪᓂᐅᑉ" ᑐᑭᖓ

ᑮᓇᐅᔭᓴᕐᓂᒧᑦ ᐱᕙᓪᓕᕐᑯᑎᑖᕐᑕᓪᓚᖓᔦᖃᕈᓂ ᐱᖅᖃᔦᕐᓯᒪᓂᕐᒦᓗᓂ, ᐱᓇᓱᑦᑎ ᐃᒣᑦᑐᓂᒃ ᖃᓄᐃᒍᑎᖃᕐᓂᕐᑫᕐᑕᐅᒋᐊᓕᒃ:

1. ᐱᖅᖃᔦᕐᓯᒪᓂᖅ **ᖃᓂᒪᓂᕐᒧᑦ, ᐊᖅᑯᓇᕐᓯᒪᓂᕐᒧᑦ, ᐱᐊᑫᑦᓴᖃᕐᓯᓂ ᖃᓄᐃᒍᑎᖃᕐᓂᕐᒧᑦ** ᐅᕙᓅᓐᓃᑦ **ᐱᓚᑦᑕᐅᒋᐊᖃᕐᓂᕐᒧᑦ ᕿᑐᕐᖏᐅᓂᕐᒨᓕᖓᔪᒥᒃ;**
2. ᖃᓂᒪᓂᕐᒧᑦ (ᐊᖅᑯᓇᕐᓯᒪᓂᕐᒧᓅᓐᓃᑦ) **ᐋᓐᓂᐊᓯᐅᕐᑎᒪᓇᓪᒧᑦ ᑲᒪᒋᔭᐅᒋᐊᖃᕐᓂᕿᓂ; ᐊᒻᒪ**
3. ᐱᖅᖃᔦᕐᓯᒪᓂᖅ ᐱᓇᓱᑦᑎᒥᒃ **ᐱᓇᓱᒐᕐᒥᓂᒃ ᐱᓇᓱᖅᖃᔦᕐᓯᒣᓂᕈᒍᑕᐅᒋᐊᓕᒃ, ᐊᓯᐊᓂᓪᓗᓃᒃ ᐱᓇᓱᒐᕐᒥᒃ ᐱᓇᓱᖅᖃᔦᕐᓯᒣᓂᕈᒍᑕᐅᒋᐊᓕᒃ** ᑌᒣᓪᓗᐊᑐᑦᓴᓇᕐᓂᒃ ᐊᑭᓕᕐᑐᑕᐅᒍᑕᐅᒍᓐᓇᑐᒥᒃ.

ᐱᒍᑦᔨᔩᑦ OSI ᐱᓇᓱᑦᑎᖓᓄᑦ ᐃᑲᔪᕐᓯᒪᔭᐅᒐᔭᕐᑐᑎᑦ ᒪᒥᓴᕐᓂᓂ. ᐱᒍᑦᔨᔩᑦ OSI ᐱᓇᓱᑦᑎᖓᓄᑦ ᐅᖃᓚᕕᐅᖃᑦᑕᓗᑎᑦ, ᐋᓐᓂᐊᓯᐅᕐᑎᑎᑦ ᐱᓇᓱᖃᑎᒋᔭᐅᓪᒥᑎᓪᓗᒋᑦ, ᐱᓇᓱᕝᕚᓗ, ᓇᐅᓕᒫᓄᑦ ᑐᓴᐅᒪᔭᐅᒋᐊᖃᙱᑐᑦ ᓲᓯᕖᓐᓇᓕᒫᑫᓯᐊᕐᓗᒥᑦ. ᐋᓐᓂᐊᓯᐅᕐᑕᐅᒍᑎᕕᓂᓕᒫᕐᐱᑦ ᐊᓪᓚᑕᐅᓯᒪᐅᑎᖏᑦ ᓇᐅᓕᒫᓄᑦ ᑐᓴᐅᒪᐅᑎᑕᐅᑦᑌᓕᑦᓯᐊᓵᕐᑐᑦ ᐊᒻᒪ ᐱᓇᓱᕝᕕᓄᑦ ᐅᑎᑭᓐᓇᓕᕐᓂᓃᕝᕕᑦ ᑐᓴᕐᑎᑕᐅᓗᓂ ᐊᖓᔪᖅᖄᑦ.

ᐱᒍᑦᔨᔩᑦ OSI ᐱᓇᓱᑦᑎᖓᓂᒃ ᖃᐅᔨᒋᐊᕐᕕᖃᖅᖄᕿᒪᒍᕕᑦ ᐅᖃᓚᕕᒋᒍᓐᓇᑌᑦ ᐅᕗᖓ 1-866-674-7656 ᐊᐱᕐᓲᑎᑦᓴᖃᕐᐱᑦ ᑭᐅᒍᓐᓇᒪᑦ.

ᐊᓪᓚᑐᖅ,

ᐱᐊᕐ ᓚᕗᖀᓐ
ᐱᓇᓱᕝᕕᒥ ᖃᓄᐃᙱᓯᐊᓇᐊᖃᕐᓂᒥᒃ ᐊᑦᑕᑐᑦᑐᒦᒥᐊᖃᕐᓂᒥᓪᓗ ᐃᑲᔪᕐᑎ
ᑲᑎᕕᒃ ᐃᓕᓐᓂᐊᓂᓕᕆᓂᕐᒥ
ᐃᓚᖃᕐᒥᔦᑦ: ᐋᓐᓂᐊᓯᐅᕐᑎᒪᓇᐅᑉ ᐅᖃᐅᓯᑦᓴᖏᓐᓂᒃ
ᐋᓐᓂᐊᓯᐅᕐᑎᒪᓇᐅᑉ ᐊᓪᓚᒋᐊᙵᑕᕕᓂᖏᓐᓂᒃ

ORGANIZATIONAL SOLUTIONS INC.
SOLUTIONS ORGANISATIONNELLES INC.

Dear Physician:

Kativik School Board is committed to assisting employees in their recovery and providing safe return to work. Kativik School Board is willing to 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.

Please complete and return the enclosed Attending Physician's Statement to 1-866-511-0008.

A Disability Management Specialist from Organizational Solutions Inc. will work with, support and help your patient during their recovery and return to work.

We thank you in advance for your assistance and invite you to contact us at 1-866-674-7656 with any questions.

Sincerely,

Stan,
Disability Management Specialist
1-866-674-7656 Ext. 3312

Encl: Attending Physician's Statement

Please Note:

"The Physician's approach to the injured / ill worker should be guided by the principle that, safe and timely return to work is the desired outcome. Developing strategies for occupational rehabilitation should begin at the patient's first visit."

CMA – Injury / Illness and Return to Work Function: A Practical Guide for Physicians (June 2000)

ORGANIZATIONAL SOLUTIONS INC.
SOLUTIONS ORGANISATIONNELLES INC.

Attending Physician Statement (APS)

Organizational Solutions Inc. ; **t:** 1-866-674-7656; **f:** 1-866-511-0008; **e:** kativikschoolboard@orgsoln.com

In order for an absence to qualify under the Employer's Short Term Disability plan, the medical documentation must contain objective clinical findings and detailed medical information which establishes the presence of a medical condition including objective evidence of an impairment severe enough to prevent your patient/client from participating in work.
This employee is applying for Short Term Disability under the Employer's Short Term Disability / Sick Leave plan.

- *It is the employee's responsibility to provide medical information to support an absence. The Employee is responsible for all fees in obtaining this information.*
- *Failure to submit this information promptly may result in the suspension of income for your patient/client.*
- *This is not a request for examination, but for information taken from your chart.*

If absence is related to surgery, this form is to be completed after the surgery has been done.
Once completed, please fax to Organizational Solutions Inc. @ 1-866-511-0008.
For additional information, please contact us at 1-866-674-7656.

To be completed by the Employee

1 Employee Information

Employer Name : Kativik School Board			
Employee First Name :		Last Name (Quebec residents include maiden name) :	
Employee Number :	Date of Birth : (mm/dd/yy)	Home Telephone :	Work Telephone :
Cell Phone :	Email Address :		
Home Address :			Occupation :
Immediate Supervisor's Name :			Telephone :
Please describe the nature of illness or injuries sustained:			

Is your illness or injury due to an accident? : ☐ Yes ☐ No

IF YES :

1) Did the accident happen at : ☐ Home ☐ Work ☐ Elsewhere
Date and Time of accident (mm/dd/yy) : _____ at _____
2) Have you or will you be applying for Workers' Compensation / CSST? (For Residents of Ontario and Quebec) ☐ Yes ☐ No
3) Is your illness or injury due to a motor vehicle accident? ☐ Yes ☐ No **If yes, enclose a copy of the accident report.**
4) Date of first absence (mm/dd/yy) : _____

When did you seek medical attention? (mm/dd/yy):	Date you returned to work or expect to return to work (mm/dd/yy):

Disability Type: ☐ **Illness** ☐ **Injury** ☐ **Work Injury** ☐ **Pregnancy** ☐ **Motor Vehicle Accident**

To be completed by the Employee

2 Authorization to Release Information

I certify that the statements in this form are true and complete.

I authorize Organizational Solutions Inc., and their respective agents and service providers to use and exchange information needed for providing advice to my employer concerning my absence under my employer's Short Term Disability / Sick-Leave plan, with any person or organization who has relevant information pertaining to my absence, including health professionals, institutions, and insurers.

I hereby authorize health care provider(s), institutions, or the LTD Insurer / WCB involved in my treatment or claim to discuss and provide all information and documents requested by the Employer and / or, Organizational Solutions Inc., their representatives, concerning my current medical or psychological health condition. I authorize Organizational Solutions Inc. to release information to the Insurer, WCB, administrators of government benefits, or health care practitioners. I authorize Organizational Solutions Inc. to share information concerning my current medical condition with the Kativik School Board's Human Resources Department relevant to my absence under my employer's salary continuance sick-leave plan. Kativik School Board will treat this information in a highly confidential manner as per Kativik School Board's internal confidentiality policy.

I also authorize Organizational Solutions Inc., and their respective agents and service providers to share functional capability information and return to work recommendations with my employer, relevant to my absence under my employer's Short Term Disability/ Sick Leave plan for the purpose of planning and managing my return to work.

I agree that a facsimile copy or a photocopy is to be considered as valid as an original signed copy.

Employee Signature : _____ Date : _____ (mm/dd/yy)

Attending Physician Statement (APS)

Organizational Solutions Inc. ; **t:** 1-866-674-7656; **f:** 1-866-511-0008; **e:** kativikschoolboard@orgsoln.com

ORGANIZATIONAL SOLUTIONS INC.
SOLUTIONS ORGANISATIONNELLES INC.

To be completed by the Attending Physician

It is the employee's responsibility to pay any cost incurred in obtaining this information.

Employee Name: _____ D.O.B. :_____

3 Physician Questionnaire

Dear Physician : *The Employer is interested in supporting ill and injured employees in their recovery and a safe, timely return to work. We ask you to complete the few questions below so that the employee can return this form as soon as possible via fax 1-866-511-0008.*

1) History

Date of 1st visit: _____ (mm/dd/yy) Date most recent visit: _____ (mm/dd/yy) Date last worked: _____ (mm/dd/yy)

a) When did symptoms first appear or accident first happen? _____ (mm/dd/yy)

b) Has your patient ever had the same or similar condition? ☐ Yes ☐ No ☐ Unknown

If yes – State when and describe: _____

_____

c) Names and specialties of other treating physicians **(Please include copies of consultation reports)** :

Name	Specialty	Frequency of Visits/ Treatments	Dates

2) Diagnosis (including complications)

a) **Primary :** _____ Secondary : _____

b) Co-morbid conditions or complications : _____

c) If **PSYCHIATRIC** diagnosis:

DSM-V Code : _____ GAF: _____

Axis II diagnosis : _____

Changes in ADL habits : _____

_____

Are patient's symptoms due to drug or alcohol abuse? _____

If yes, is patient enrolled in a substance abuse program? _____

d) If **OBSTETRICAL** diagnosis: Expected date of confinement : _____ (mm/dd/yy)

e) **Objective and clinical findings – Please be specific** – pertinent physical findings (including severity, frequency):

_____

_____

_____

f) Signs and Symptoms : _____

3) Treatment Plan :

a) Hospital Admission – Admission Date: _____ (mm/dd/yy) Discharge Date: _____ (mm/dd/yy)

Surgery: ☐ Yes ☐ No Date: _____ (mm/dd/yy)

Surgical procedure: _____

b)

Medication	☐ Yes	☐ No	Physio	☐ Yes	☐ No
Lab / X-Ray	☐ Yes	☐ No	Counselling	☐ Yes	☐ No
Referral	☐ Yes	☐ No	Other (specify) :		

APS (Continued)

Organizational Solutions Inc. ; **t:** 1-866-674-7656; **f:** 1-866-511-0008; **e:** kativikschoolboard@orgsoln.com

Employee Name : _____ D.O.B. : _____

Physician Questionnaire (Continued)

c) Medication (attach page if required) :

Name	Dose	Date Begun	Date Changed and Reason	Response

d) Current and proposed treatment – include frequency and duration (e.g. physio, counselling, radiation, chemo)

_____

_____

e) Compliance – Is your patient compliant with the recommended treatment program?

☐ Yes ☐ No (please elaborate)_____

Note: Modified work is available to accommodate most limitations and restrictions

5) Functional Capacity

PLEASE PROVIDE CAPABILITIES Estimated Duration of limitations: _____

A.SITTING / STANDING / WALKING	OCCASIONAL (0-33%)	FREQUENT (34-66%)	NO LIMITATIONS	COMMENTS
Sitting / Standing	☐	☐	☐	Distance
Walking	☐	☐	☐	Height/frequency
Climbing	☐	☐	☐	Body part affected
Continuous Bending / Twisting	☐	☐	☐	
B. LIFTING FLOOR TO WAIST				
Sedentary (up to 4.5 kgs)	☐	☐	☐	
Light (4.6 - 9.0 kgs)	☐	☐	☐	
Medium (9.1 – 22kgs)	☐	☐	☐	
C. LIFTING WAIST TO SHOULDER				
Sedentary (up to 4.5 kgs)	☐	☐	☐	
Light (4.6 - 9.0 kgs)	☐	☐	☐	
Medium (9.1 – 22kgs)	☐	☐	☐	
D. COGNITIVE CAPABILITIES				
Verbal Communication	☐	☐	☐	
Attention to Detail	☐	☐	☐	
Concentration	☐	☐	☐	
Able to follow and provide instructions	☐	☐	☐	

Are there any psychological stressors (Axis IV) that may affect return to work? Please check (✔) and indicate Functional Limitations:

☐Problems related to the social environment:_____ ☐Other psychosocial and environmental problems: _____

☐Problems with access to health care services: _____ ☐Workplace Issues: _____

6) Prognosis

a) To the best of my knowledge, this Employee is totally disabled from: Date : _____ (mm/dd/yy) to Date:_____ (mm/dd/yy)

b) What is the prognosis for return to regular unrestricted work?: _____

c) What are the factors affecting your patient's progress?: _____

_____

d) Is complete recovery expected? ☐ Yes ☐ No

Notice to Physician

Any information provided by me to OSI regarding this claim may be disclosed to the Employee and / or those authorized by him / her to receive such disclosure unless I notify OSI in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect to the health of the Employee or result in harm to a third party.

_____ _____

Physician Signature Date (mm/dd/yy)

_____ _____

Physician Name – Please Print Specialty

_____ _____

Street City Province Postal Code

Telephone Number _____ Fax Number _____