Seneca College
of Applied Arts and Technology

Personal and Confidential

Human Resources Department **Fax # (905)948-9375**

EMPLOYEE MEDICAL REPORT

Seneca College is committed to establishing safe and early return to work opportunities for employees returning from injury or illness. The College will support returning employees and every reasonable effort will be made to accommodate those who are unable to perform their regular duties as a result of illness, injury, diminished capacity or disability. With the information provided by the health professional, the College's Return-to-Work Specialist will develop an appropriate return to work plan, with the aid and cooperation of the employee, union representative (if applicable) and supervisor.

Please note the following two pages (applicable sections) must be completed by the treating health professional:

Employee's Name:	Date of Assessment:
Health Professional's Name (please print):	
Address (please print):	
Phone Number:	Fax Number:

General Nature of illness/injury resulting in absence/accommodation:
Employee has been absent/accommodated since:

Please complete all that apply:

RETURN TO WORK Employee may immediately return to full duties and has no physical or functional limitations.	☐ Yes Date of return:	☐ No If no, see following applicable question(s)

CONTINUED ABSENCE

Employee requires an extended absence from work and will be reassessed on: _____

Anticipated date of return to work: _____

OR

GRADUAL RETURN TO WORK/ACCOMMODATION PROGRAM

Employee can participate in a gradual return to work/accommodation program. Please state appropriate time frames. (***Important*** - indicate the employee's physical restrictions and/or functional limitations on the next page)

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Have you recommended a course of treatment to assist the patient to resume full time status?	☐ Yes	☐ No
Is the employee participating in the treatment to assist him/her to resume full time status?	☐ Yes	☐ No

Employee has the following physical restrictions imposed by the condition: (Check as applicable)

Walking: ☐ Up to 100 metres ☐ 100-200 metres ☐ Other (please specify)	Standing: ☐ Up to 15 minutes ☐ 15-30 minutes ☐ Other (please specify)	Sitting: ☐ Up to 30 minutes ☐ 30 minutes – 1hr ☐ Other (please specify)	Lifting from floor to waist: ☐ Up to 5 kg ☐ 5 – 10 kg ☐ Other (please specify)
Lifting from waist to shoulder: ☐ Up to 5 kg ☐ 5 – 10 kg ☐ Other (please specify) _____	Stair climbing: ☐ Up to 5 steps ☐ 5 – 10 steps ☐ Other (please specify) _____	Ladder climbing: ☐ 1 – 3 steps ☐ 4 – 6 steps ☐ Other (please specify) _____	Travel to work: Ability to use public transit ☐ Yes ☐ No Ability to drive a car ☐ Yes ☐ No
☐ Bending/twisting repetitive movement of (please specify) _____	☐ Work at or above shoulder activity:	☐ Limited pushing/pulling:	

Any additional physical restrictions:
List any assistive devices/modifications you feel would be beneficial:

Employee has the following functional limitations imposed by the condition:

If your patient has any functional limitations, please list: ▪ ▪ ▪ ▪ ▪

Recommended date of next appointment to review restrictions/limitations:

I hereby declare that the information being submitted is true and complete. Health Professional's Signature:	Date:

If convenient, the completed form and invoice can be faxed to my attention at (905)948-9375. As per the Ontario Medical Association's fee schedule.

Thank you for taking the time to complete this form. It is a valuable tool in a successful return to work process. If you have any questions please do not hesitate to contact me at (416) 491-5050, extension 77157.

Sincerely,

Marianne Cunningham
Return-to-Work Specialist