peel District School Board
5650 Hurontario Street
Mississauga, ON, Canada L5R 1C6

Health Promotion Program – Chronic Health Condition/Disability - Attending Physician Statement – Appendix L

Your patient has brought this form to you for completion. The Peel District School Board (PDSB) is committed to assisting our employees to attain optimal health and well-being. In September 2016, the PDSB initiated an Health Promotion Program . The purpose of this Program is to support our valued employees and assist them in optimizing their health with a view to maximizing their ability to attend work on a regular basis.

Section A: Employee Information (please print)	
Employee Name:	Position:
School/Department Name:	Employee ID Number P00
Name of Immediate Supervisor:	Phone Number:

Section B: Section B: to be completed by the primary health care professional that is managing the patients chronic health condition (please print)
Personal information on this form is collected in accordance with the Municipal Freedom of Information and Protection of Privacy Act, 1990, Section 32, Health Protection and Promotion Act RSO 1990, and the Personal Health Information Protection Act, 2004. The information gathered on this form is confidential medical information to be submitted directly to the Abilities Management/Occupational Health Office, Peel District School Board. This information will not be released or shared without your written consent. https://intranet.peelschools.org/Board/Documents/HRS%2045.pdf

Is your patient suffering from a chronic health care condition/disability?	Yes ☐ No ☐
What is the general nature of illness (not diagnosis)?	
How long have you been treating your patient for this chronic condition/disability (date of disability)?	Specialist oversees care of health condition/disability ☐ A referral has been initiated to a Specialist ☐
In your medical opinion, how frequently will your patient require time off work directly to the chronic condition/disability?	☐ Sporadically: 1-3 days over a course of three months ☐ Occasionally: 1 – 6 days over the course of three months ☐ other: please specify_____
Is the condition(s) stable?	Yes ☐ No ☐
Is your patient in a current treatment plan?	Yes ☐ No ☐
When you patient is absent from work due to this chronic medical condition/disability, what restrictions and limitations (do not include diagnosis) prevent them from attending work. _____ _____ _____	
Given the above information, in your professional opinion, has the condition reached maximum medical recovery?	Yes ☐ No ☐

Name of Health Care Provider (please print):	Health Care Provider Office Stamp:
Health Care Provider Signature:	
Date of Assessment(dd/mm/yyyy):	

Please submit the completed Attending Physician Statement to the Abilities Office:
Confidential Fax: 905-890-0485 or Scan/Email HealthPromotion@peelsb.commailto:abilities.office@peelsb.com
Employee is responsible for any charge made for the completion of the Attending Physician Statement

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