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

Attending Physician Statement (APS)# 001

Please complete this form in its entirety as soon as possible to expedite the processing of your claim for sick benefits under the Peel District School Board employment provisions. **A completed Employee Statement with all relevant and pertinent information must be completed if an illness absence reaches/exceeds 5 consecutive days of the start of the disability** to avoid interruptions in pay**.**

(This form is not to be used for workplace related injuries/illnesses: Workplace Safety and Insurance Board – WSIB. Please contact the Abilities Office at 905-890-1010 ext. 2428 to request a WSIB Functional Abilities Form.)

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

Section B: Consent to Release (Employee to sign)

By signing below, I consent to allow my physician completing this form to provide information to Peel Abilities Office concerning the specific absence from work identified on this form, relevant purpose(s) of determining eligibility for short term disability leave benefits; approving an unpaid medical leave of absence; and/or facilitating an early and safe return to work. I understand that all information will be treated in a highly confidential manner and only information regarding my return to work or any related limitation and accommodations will be shared with my Supervisor. I agree that a facsimile copy or a photocopy of this Form and any other related documents will be considered valid, original copies.

Please be aware, your union will be copied on all medical leave of absence correspondence unless you provide a request in writing to the Abilities Office requesting your union representative is not to be provided with such information. You can email your request to the abilities.office@peelsb.com.

Employee Signature: **Date:**

Section C: to be completed by attending physician or health care professional (please print)

TOTALLY/SUBSTANTIALLY DISABLED – unable to perform the regular duties pertaining to the occupation in which you participated in immediately before becoming disabled. **Based on your findings and clinical observations (do not include diagnosis), please outline and describe your patients cognitive and/or physical restrictions/ limitations/ symptoms that is presently impacting your patient's ability to work:**

Please specify the objective medical assessment tool used to determine the above noted restrictions: (Examples: Lifting Tests, Grip Strength Tests, Beck Depression, Anxiety Inventories, Self- Reporting, DM Guidelines etc.)

Please submit the completed APS to the Abilities Office:
Confidential Fax: 905-890-0485 or Scan/Email abilities.office@peelsb.com
Employee is responsible for payment to health care provider for the completion of this Form.
(Employees will be reimbursed by the Peel DSB upon receipt of invoice)

Revision date: March 2018

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

Attending Physician Statement (APS) # 001

Employee Name:	**Employee ID Number P00**	**Page 2**
First day employee unable to work: (dd/mm/yyyy)	Is the condition arising from employment? Yes ☐ No ☐	
Has the employee been referred to a specialist licensed to practice medicine in Ontario? Yes ☐ No ☐ If yes, specify referral date_____		
To your knowledge, is the employee compliant with the recommended treatment plan? Yes ☐ No ☐		
Is the employee under your active and continuous care: Yes ☐ No ☐		
Prognosis for return to work: ☐10 - 15 days ☐16- 25 days ☐26 - 40 days ☐ 40 + days ☐ Initiate Long Term Disability		
Is the employee capable of returning to: Modified duties: ☐ No ☐ Yes, effective when: _____(dd/mm/yyyy): Regular duties with no restrictions: ☐ No ☐ Yes, effective when: _____(dd/mm/yyyy):		
Please outline any specific restrictions to assist the Peel DSB with appropriate accommodation: **Please specify functional restrictions and limitations based on physical or emotional capabilities**. Based on this information the Peel Abilities Designate will facilitate return to work with all the workplace stakeholders and develop an appropriate temporary/transitional accommodation plan. What is the estimated duration of the restrictions: _____ Expected return to work (full duties) date (dd/mm/yyyy): : _____		

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

Peel District School Board has an Employee and Family Assistance Program (EFAP) because it recognizes employees are its most valuable asset. Homewood Health EFAP, available 24 hours a day, 7 days a week by phone, Internet or in person.
Homewood Health 1-800-663-1142 www.homeweb.ca

Please submit the completed APS to the Abilities Office:
Confidential Fax: 905-890-0485 or Scan/Email abilities.office@peelsb.com
Employee is responsible for payment to health care provider for the completion of this Form.
(Employees will be reimbursed by the Peel DSB upon receipt of invoice)

Revision date: March 2018