



District 13

Ontario Secondary School Teachers' Federation

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Instructions for Use of the Abilities Form

There is a Province-wide medical certificate (*Abilities Form*) that all members will use in order to access sick days for an absence of three days or longer. **The Abilities Form will replace all DDSB medical certificates for OSSTF members.** This standard form is readily available on our website so there will be less confusion regarding the provision of medical documentation to the Board. The Abilities Form is available at any time on our website at www.d13.osstf.ca/abilitiesform.

It is very important to read Section 1 closely as it will determine how the rest of the form is to be completed. When you are assessed by your doctor, he/she will determine your suitability to work in one of three ways:

- a) Able to work with no restrictions;
- b) Able to work with specific restrictions;
- or
- c) Unable to work at all.

There are three check boxes in Section 1 where your doctor will indicate his/her assessment. The selection here will determine which other sections of the form need to be completed. Ensure that the doctor completes **only** those sections which are required to be completed.

Continued on next page...

Once completed by your doctor, you must submit your Abilities Form to the Ability Management Department at the DDSB. All of your medical documentation is housed and adjudicated by Ability Management, a confidential department tasked with administering the sick leave plan. **All medical notes and information should be sent directly to Ability Management and not to your Principal or secretary.** Keep a copy of all notes for yourself. All your school will be told is which days to call in a supply teacher. If you are off for a prolonged period, simply call your school's attendance line and indicate that you will not be at work and that you are submitting medical to Ability Management. (For PSSPs, contact your supervisor as appropriate.)

Here is the contact information to submit your Abilities Form to the Ability Management Department:

-confidential fax line: (905) 666-6953

-email: ShortTerm.Absence@ddsb.ca (There are a handful of employees in that department and the initial contact will transfer your case file to one of them.)

-department phone: (905) 666-6342

-DDSB courier c/o Ability Management, DDSB Education Centre

If you need any assistance through this process, please contact the OSSTF District 13 Benefits Officer Nicole Bléau at (905) 668-7100 or nicole.bleau@d13.osstf.ca. Also, if you are submitting an Abilities Form for an absence of 15 days or longer, be sure to notify Nicole Bléau.

See over for Abilities Form...

APPENDIX B – ABILITIES FORM

Employee Group:	Requested By:
WSIB Claim: <input type="checkbox"/> Yes <input type="checkbox"/> 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: <i>(Please print)</i>	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 <i>(please do not include diagnosis)</i> : _____
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: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 100 metres <input type="checkbox"/> 100 - 200 metres <input type="checkbox"/> Other <i>(please specify)</i> :	Standing: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 15 minutes <input type="checkbox"/> 15 - 30 minutes <input type="checkbox"/> Other <i>(please specify)</i> :	Sitting: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 30 minutes <input type="checkbox"/> 30 minutes - 1 hour <input type="checkbox"/> Other <i>(please specify)</i> :	Lifting from floor to waist: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other <i>(please specify)</i> :								
Lifting from Waist to Shoulder: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 kilograms <input type="checkbox"/> 5 - 10 kilograms <input type="checkbox"/> Other <i>(please specify)</i> :	Stair Climbing: <input type="checkbox"/> Full abilities <input type="checkbox"/> Up to 5 steps <input type="checkbox"/> 6 - 12 steps <input type="checkbox"/> Other <i>(please specify)</i> :	<input type="checkbox"/> Use of hand(s): <table border="0"> <tr> <td>Left Hand</td> <td>Right Hand</td> </tr> <tr> <td><input type="checkbox"/> Gripping</td> <td><input type="checkbox"/> Gripping</td> </tr> <tr> <td><input type="checkbox"/> Pinching</td> <td><input type="checkbox"/> Pinching</td> </tr> <tr> <td><input type="checkbox"/> Other <i>(please specify)</i>:</td> <td><input type="checkbox"/> Other <i>(please specify)</i>:</td> </tr> </table>		Left Hand	Right Hand	<input type="checkbox"/> Gripping	<input type="checkbox"/> Gripping	<input type="checkbox"/> Pinching	<input type="checkbox"/> Pinching	<input type="checkbox"/> Other <i>(please specify)</i> :	<input type="checkbox"/> Other <i>(please specify)</i> :
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<input type="checkbox"/> Other <i>(please specify)</i> :	<input type="checkbox"/> Other <i>(please specify)</i> :										

APPENDIX B – ABILITIES FORM

<input type="checkbox"/> Bending/twisting repetitive movement of (please specify):	<input type="checkbox"/> Work at or above shoulder activity:	<input type="checkbox"/> Chemical exposure to:	Travel to Work: Ability to use public transit _____ Ability to drive car _____	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2B: COGNITIVE (please complete all that is applicable)				
Attention and Concentration: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Following Directions: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Decision- Making/Supervision: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Multi-Tasking: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	
Ability to Organize: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Memory: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Social Interaction: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> Comments:	Communication: <input type="checkbox"/> Full Abilities <input type="checkbox"/> Limited Abilities <input type="checkbox"/> 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 (should/must not do) for all medical conditions:				
3: Health Care Professional to complete.				
From the date of this assessment, the above will apply for approximately: <input type="checkbox"/> 6-10 days <input type="checkbox"/> 11- 15 days <input type="checkbox"/> 16- 25 days <input type="checkbox"/> 26 + days			Have you discussed return to work with your patient? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Recommendations for work hours and start date (if applicable): <input type="checkbox"/> Regular full time hours <input type="checkbox"/> Modified hours <input type="checkbox"/> Graduated hours			Start Date: _____ dd mm yyyy	
Is patient on an active treatment plan?: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Has a referral to another Health Care Professional been made? <input type="checkbox"/> Yes (optional - please specify): _____ <input type="checkbox"/> No				
If a referral has been made, will you continue to be the patient's primary Health Care Provider? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	_____