District 13
Ontario Secondary School Teachers' Federation
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Email: district13@d13.osstf.ca Website: www.d13.osstf.ca

Instructions for Use of the Abilities Form

OSSTF members are required to have an abilities form completed to support access to sick leave for an absence of more than three consecutive days.

The abilities form can be accessed on our District 13 OSSTF website at www.d13.osstf.ca/abilitiesform or by calling a District 13 OSSTF TBU representative in the office.

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, they 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 their 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…

Submit your completed Abilities Form to the Ability Management Department at the DDSB.

- confidential fax line: (905) 666-6953
- email: ShortTerm.Absence@ddsb.ca
    - this can be an electronic copy of the document or
    - pictures taken with your phone
- DDSB courier c/o Ability Management, DDSB Education Centre

The DDSB Abilities Management Department can be reached by phone at (905) 666-6342.

Information to Consider:

- 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, school clerical or supervisor.**
- Keep a copy of all notes for yourself.
- If you are off for a prolonged period, call your school's attendance line and indicate that you will not be at work and that you are submitting medical to Ability Management.

If you need any assistance through this process, please contact a District 13 OSSTF TBU representative at (905) 668-7100. If you are submitting an Abilities Form for an absence of 15 days or longer, be sure to notify a District 13 OSSTF TBU representative.

See over for Abilities Form…

APPENDIX B – ABILITIES FORM

Employee Group:	*Requested By:*
WSIB Claim: ☐ *Yes* ☐ *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: *(Please print)*	**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 (***please do not include diagnosis***): _____

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:	**Standing:**	**Sitting:**	**Lifting from floor to waist:**
☐ Full Abilities	☐ Full Abilities	☐ Full Abilities	☐ Full Abilities
☐ Up to 100 metres	☐ Up to 15 minutes	☐ Up to 30 minutes	☐ Up to 5 kilograms
☐ 100 - 200 metres	☐ 15 - 30 minutes	☐ 30 minutes - 1 hour	☐ 5 - 10 kilograms
☐ Other (*please specify*):	☐ Other (*please specify*):	☐ Other (*please specify*):	☐ Other (*please specify*):

Lifting from Waist to Shoulder:	**Stair Climbing:**	☐ **Use of hand(s):**	
		Left Hand	**Right Hand**
☐ Full abilities	☐ Full abilities	☐ Gripping	☐ Gripping
☐ Up to 5 kilograms	☐ Up to 5 steps	☐ Pinching	☐ Pinching
☐ 5 - 10 kilograms	☐ 6 - 12 steps	☐ Other (*please specify*):	☐ Other (*please specify*):
☐ Other (*please specify*):	☐ Other (*please specify*):		

☐ **Bending/twisting** repetitive movement of (*please specify*):	☐ **Work at or above shoulder activity**:	☐ **Chemical exposure to**:	**Travel to Work**: Ability to use public transit _____ Ability to drive car	☐ Yes ☐ No _____ ☐ Yes ☐ No

2B: COGNITIVE (*please complete all that is applicable*)

Attention and Concentration: ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Following Directions:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Decision-Making/Supervision:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Multi-Tasking:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:
Ability to Organize: ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Memory:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Social Interaction:** ☐ Full Abilities ☐ Limited Abilities ☐ Comments:	**Communication:** ☐ Full Abilities ☐ Limited Abilities ☐ 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 (<u>should/must</u> not do) for all medical conditions**:

3: Health Care Professional to complete.

From the date of this assessment, the above will apply for approximately: ☐ 6-10 days ☐ 11- 15 days ☐ 16- 25 days ☐ 26 + days	Have you discussed return to work with your patient? ☐ Yes ☐ No
Recommendations for work hours and start date (if applicable): ☐ Regular full time hours ☐ Modified hours ☐ Graduated hours	Start Date: **dd mm yyyy**

Is patient on an active treatment plan?: ☐ Yes ☐ No

Has a referral to another Health Care Professional been made?
☐ Yes (optional - please specify): _____ ☐ No

If a referral has been made, will you continue to be the patient's primary Health Care Provider? ☐ Yes ☐ 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:	_____