





GENERIC TREATMENT MEMORANDUM & FUNCTIONAL ABILITIES

EMPLOYEE: All sections must be completed to ensure approval of sick leave entitlement and associated benefits.

A. EMPLOTEE TO COMP	LETE					
Employee Name:		Employee Number:		Phone:	Phone:	
Job Title: Worl		Work Location:	Nork Location:		Supervisor Name:	
B. HEALTH CARE PROFESS	ONAL TO COMPLETE	- Please identify	y your patient's overall abi	lities and resti	rictions.	
The Region is requesting the accommodation or in certain ca	at our employee receive ses confirm eligibility for	from you an assessick leave entitle	essment that will assist with ment. For more information	an appropriate please call 90	workplace 5-685-4225 ext. 3636.	
1. Date of Assessment Illness / Injury Con			ed Accident / Illness (Circle One)			
			Work Related Not Work F	Related Linknow	n Motor Vehicle Accident	
DD MM YYYY	DD N	MM YYYY				
			Nature of Current Illness/Injury (Not Diagnosis):			
_	to work with no restric	oilities until	DD MM YYYY			
Walking: Full abilities Short distances only Other:	Standing: Full abilities 15 - 30 minutes < 15 minutes Other Duration:	□ 30 mir □ < 30 n	☐ Full abilities☐ 30 minutes - 1 hour☐ < 30 minutes		Stair Climbing: Full Abilities Short flights only No load:	
Lifting from waist to shoulder: Full abilities < 25 kg < 10 kg Other:	Lifting from floor to waist: Full abilities < 25 kg < 10 kg Other:	Pushing □ Full a □ 10 kg- □ < 10 k	Pulling: Ability to use Hands: Left Right Full Abilities Limited Keyboarding/Writing Limited Gripping		ds: Right a oarding/Writing ing	
Bending/Stooping: Full Abilities 1 - 3 hour's / day < 1 hour / day Other:	Repetitive Movements: Full Abilities Restrictions (Details):	□ Res	mment on any Limitations: ricted hours of work:hours/dayhours/week rating motorized equipment/machinery effects from medications: Ability to drive: Yes No			
A11 12 16 17 17 17 17 17 17 17 17 17 17 17 17 17	COGNITIVE	Restrictions	☐ No ☐ Yes (Specify)			
Attention (focus and concentration): No Deficit Minimal Moderate Major	□ No Deficit □ Minimal □ Moderate		otional (coping, social interaction) lo Deficit ⁄linimal ⁄loderate ⁄lajor	Scale:	Global Assessment of Functioning (GAF) Scale: Score:	
Other Restrictions / Comn	nents:			I		

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Employee Name:						
3. Physician and Patient Follow Up						
Is this a recurrence of a previous illness/injury? No						
Has a referral to another Health Care Professional been made? □ Yes (optional – please specify): □ No						
If yes, will you continue to be the patient's primary health care practitioner? Yes No						
Date of next appointment to review Abilities and/or Restrictions:						
Health Care Professional's Name (Please print):						
Signature:						
Date:						
Phone Number:	Fa	Fax Number:				
C. EMPLOYEE TO COMPLETE - Author	rizations for Release of Information					
I hereby authorize my treating Health Professional (name) to release the information requested on this Form. The information provided, with exception of the nature of the current illness/injury will be disclosed to my responsible manager/supervisor of the corporation and/or Human Resource Representatives as per			Employee Signature:			
the Work Accommodation Policy (C3.T05) to certify my entitlement to medical benefits, ensure my safety, assist in proper job placement and to accommodate a disability. A photocopy of this authorization will be considered as the original.			Date:			
If clarification regarding what is recorded on this Form return to work I authorize the Occupational Health Nu	Employee Signature:					
photocopy of this authorization will be considered as to pursuant to this paragraph.		Date:				
	Health Professional (name) Health Nurse/Department and I also authorize the Occu he above-noted Health Professional. A photocopy of th					
Employee Signature:	Date:					
Nurse requires additional information not contained in you that it is requesting additional information (check It is not necessary to notify me OR Call me ar	e or she first provides his or her Treatment Memorandu the Treatment Memorandum Form. Please identify be one): id leave a message at t do not leave a message if I am not available (no furthe	elow if you wi	sh the Occupational Health Department to notify available (only one phone call will be made). OR			

PLEASE RETURN THE COMPLETED FORM:

Via Confidential Fax at (905)-685-5355 (Do not fax to your Manager) or

Via Email to ehs@niagararegion.ca or

Via Internal Mail Delivery to: Human Resources

c/o Disability Management Coordinator

Tel: 905-685-1571 Ext. 3636 Contact:

- This form is also available on-line at https://remote.niagararegion.ca
 Cost of this form is the responsibility of the patient. Reimbursement will be provided for the reasonable and customary cost to complete this form by submitting the original receipt to Employee Health Services.

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