Homewood Health | Santé

Medical to Support General Illness Benefits

This form is used by support staff to provide Proof of Illness when the illness is known initially to be for more than ten working days or the illness continues for more than ten working days.

Homewood Health is the University of Alberta's Disability Management Service Provider.

For assistance with this form, please contact Homewood Health Inc. at HHI confidential email disabilitymanagement@homewoodhealth.com

Fax to HHI at 780-429-1747 or 1-888 429-1747.

University of Alberta Staff Member Information

First Name _____ Last Name _____ Job Title _____

First Day Off Work Due to Illness (dd/mm/yyyy)_____ Date of Office Visit (dd/mm/yyyy) _____

Medical Assessment

The University of Alberta is committed to supporting staff members during medical treatment and in their return to work. Your comments below will assist in assessing entitlement to sick leave benefits and in developing an effective rehabilitation plan and a safe, timely and sustainable return to work.

"The CMA recognizes the importance of a patient returning to all possible functional activities relevant to his or her life as soon as possible after an injury or illness. Prolonged absence from one's normal roles, including absence from the workplace, is detrimental to a person's mental, physical and social well-being. A safe and timely return to work benefits the patient/employee and his or her family by enhancing recovery and reducing disability." - 2013 Canadian Medical Association Policy Statement

1. Outline the objective medical findings that indicate your patient is currently unable to attend work and perform either their regular duties or modified or alternate duties/hours.

2. Please indicate:
   a. The prognosis for full recovery, including the expected duration of the illness or injury: _____
   b. An estimated date for a return to regular/modified/alternate duties or hours of work (dd/mm/yyyy): _____
   c. Date your patient will be reassessed by you (dd/mm/yyyy): _____

3. Please indicate your patient's current functional ability:

Work Level	Pace of Work	# of Hours per day	# Shifts per week	# of Weeks to return to Regular hours/duties
❑ Sedentary ❑ Light ❑ Medium ❑ Heavy	❑ Regular Pace ❑ Moderate Pace ❑ Light Pace	❑ 2 ❑ 4 ❑ 6 ❑ Full Day	❑ 2 ❑ 3 ❑ 4 ❑ 5	❑ 1 ❑ 2 ❑ 3 ❑ 4
In addition to the above information, please outline all other medical restrictions and limitations to be considered in developing a supportive return to work plan allowing your patient to return to modified or alternate work hours or duties before they are fit for their regular duties. Please note the duration of each restriction. The University will accommodate medical restrictions and limitations to support an early and safe return to work.				

4. When appropriate, Homewood Health Inc. may assist in facilitating referral or treatment recommendations. Please identify which options below we may assist with:

❑ Ergonomic Assessment ❑ Nutrition or Dietitian Referral ❑ Physiotherapy
❑ Psychological Counseling ❑ Other _____

Physician Information – If more convenient, please verify the following information with your office stamp.

Name of Physician _____

Address _____ Phone _____ Fax _____

Signature _____ Date (dd/mm/yyyy) _____

The personal information requested on this form is collected under the authority of Section 33 (c) of the Alberta Freedom of Information and Protection of Privacy Act and will be protected under Part 2 of that Act. It will be used for the purpose of managing your health and wellness information. Direct any questions about this collection to privacy@homewoodhealth.com

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