MEDICAL FITNESS

Policy E.1.G

Frontier School Division recognizes that on occasion, employees may experience health conditions that prevent them from attending work. Should an employee's health or frequency of absences from work become a cause for concern, the Division may require additional medical information from the employee including a physical or psychiatric examination by a duly qualified medical practitioner acceptable to the Division. The information requested will be general in nature regarding the illness or disability and will focus upon and verify the prognosis or expectation for recovery and the possible date for return to work.

The cost of any examination will be paid by the Division.

Adopted September 1, 2009		

1. Procedures for Medical Fitness Examinations

In cases of long-term or frequent sick leave claims, the Chief Superintendent may require an employee to have a physical or psychiatric examination. The following procedures will be used:

a. The Chief Superintendent shall inform the employee in writing and shall designate the medical practitioner who shall perform the examination;

b. An employee so informed shall sign a release of information form (Exhibit E.1.G – EX1);

c. The medical practitioner's report (Exhibit E.1.G – EX2) shall be submitted to the Division. A copy will be made available to the employee;

d. Information from the medical practitioner shall be treated with the strictest confidence and shared only on a need to know basis.

Adopted September 1, 2009		

FRONTIER SCHOOL DIVISION AUTHORIZATION OF EMPLOYEE

Exhibit E.1.G-EX1

TO: _____
(Medical Practitioner)

I _____ hereby consent to having the information as outlined in the Medical Practitioner's Report, requested under Policy E.1.G, Medical Fitness, provided to the Human Resources Coordinator, Frontier School Division.

_____ _____
(Employee Signature) (Date)

_____ _____
(Witness) Date)

Adopted September 1, 2009		

MEDICAL PRACTITIONER'S REPORT
WORKPLACE CAPABILITIES/RETURN TO WORK

Exhibit E.1.G-EX2

Dear Dr._____

Frontier School Division accommodates employees to aid in the early and successful rehabilitation of ill or injured workers. In order to identify appropriate work, Frontier School Division requests your assistance by completing this form, which will provide the employee with duties within the employee's capabilities given your assessment of his/her capabilities. Please complete Sections A, B, C, as applicable. Your cooperation is appreciated.

This certifies that I have thoroughly examined _____
(Name of Patient)

Date of last attendance on employee_____

Section A

1. Does employee have a medical condition that would prevent him/her from attending work and performing his/her duties full-time as described in the attached job description?

   Yes_____ No _____

   If Yes, can employee carry out his/her duties on a part-time basis with no restrictions:

   Yes _____ No _____

   If Yes, what percent of full time _____

Section B

2. Employee may return to modified work, with restrictions, as indicated below:

   Yes_____ No _____ If Yes, please complete the following:

   a. Employee is able to do the following: (Please check column that applies)

Action	No Restrictions	Continuous 67% - 100%	Frequent 34% - 66%	Occasional Up to 33%	Not at all
Standing					
Walking					
Sitting					
Working with hands above shoulders					

Action	No Restrictions	Continuous 67% - 100%	Frequent 34% - 66%	Occasional Up to 33%	Not at all
Reaching within body envelope					
Reaching outside body envelope					
Bending					
Twisting					
Squatting					
Kneeling					
Climbing					
Repetitive hand/wrist/elbow: Right - flexion/extension - radial/ulnar deviation					
Left - flexion/extension - radial/ulnar deviation					
OTHER:					

b. Employee can lift/carry:

(a) Floor to waist: ❑ less than 2 kg ❑ 2 kg to 10 kg ❑ 10 kg to 23 kg ❑ No restrictions

(b) Waist to shoulder: ❑ less than 2 kg ❑ 2 kg to 10 kg ❑ 10 kg to 23 kg ❑ No restrictions

c. Is employee restricted by environmental factors such as heat/cold, dust, chemical fumes, etc.?

Yes _____ No _____ If Yes, please explain:

_____

_____

d. Is employee required to wear or use assistive equipment?

Yes _____ No _____ If Yes, please explain:

_____

_____

e. Is employee involved with treatment and/or medications that may affect his/her ability to perform some or all of the assigned duties or which could affect the safety of the employee or others?

Yes _____ No _____ If Yes, please explain:

_____

_____

f. Are there any other specific stressors/situations that would affect employee's ability to perform some or all of the assigned duties?

Yes _____ No _____ If Yes, please explain:

_____

_____

g. Additional information that you feel would be pertinent and beneficial in order to facilitate employee regularly attending work.

_____

_____

h. Recommendation for work hours:

_____ Full-time hours, OR _____ Graduated hours as follows:

_____ number of hours for _____ number of weeks, increasing to:

_____ number of hours for _____ number of weeks.

Employee will return to full-time work on _____ OR

Date of next attendance on employee _____

i. Has employee been referred to a specialist who would have relevant information concerning the employee's return to work?

Yes _____ No _____

If yes, referred to Dr. _____

Address_____

MEDICAL PRACTITIONER'S REPORT
WORKPLACE CAPABILITIES/RETURN TO WORK
Exhibit E.1.G-EX2

Section C

Employee is totally disabled.

Estimated duration of absence from work: _____ Days _____ Weeks

Date of next attendance on employee: _____

In accordance with the consent form attached, I provide this report to Frontier School Division and to employee.

Medical Practitioner's Name and Address: _____

_____

_____

Phone: _____

Fax: _____

_____ Date: _____
(Signature of Medical Practitioner)

Adopted September 1, 2009		