OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

Employee Sick Leave Information and Instructions

1. If you have an illness/injury and require time off work please notify your Supervisor as per your regular absence reporting process. Injury or illness that resulted in the course of your employment must be reported to your supervisor for reporting to the WSIB.

2. If you are or will be absent for 6 days or more, or your short term absence is extended to 6 days or more please obtain a sick leave package from your supervisor.

3. Take the Standardized Medical Certificate to your health care professional for completion. Part A and Part B are to be completed in all cases. Part C is to be completed if you require accommodation upon your return to work.

4. Please ensure that your return the completed form to the Employee Wellness confidential fax **613-596-8798** or with your consent your health care professional may fax it directly.

5. If you require assistance during your absence or with return to work planning please contact your Disability Management Coordinator as follows:

   Christine Marleau – DMC – 613-596-8211, ext. 8335
   (Employee last name A-K)

   Kim Benson – DMC – 613-596-8211, ext. 8270
   (Employee last name L-Z)

6. In some cases, your Disability Management Coordinator may call you to offer support during your absence.

7. Ottawa-Carleton District School Board will provide accommodations and transitional return to work options, if available, and if you require it, in order to assist in your return to work.

8. The Standardized Medical Certificate may be requested throughout your absence dependent upon your individual circumstances.

9. The completed Standardized Medical Certificate supports your absence due to illness / injury and access to paid sick leave entitlement.

10. If there is a fee associated with the completion of the Standardized Medical Certificate, please submit proof of payment to Employee Wellness for reimbursement.

Attached: Standardized Medical Certificate
Health Care Professional Letter

OTTAWA-CARLETON
DISTRICT SCHOOL BOARD

Dear Health Care Professional:

The Ottawa-Carleton District School Board (OCDSB) is committed to assisting employees in their recovery and providing safe return to work. The OCDSB will provide transitional modified duties and/or modified hours of work, if required.

Employees must provide sufficient objective medical documentation to support their absence, to qualify for benefits, and to assist in the development of a return to work plan appropriate to the employee's abilities and limitations.

Attached is the OCDSB standardized medical form. Part B of the form is to be completed for all employees. Please complete only the applicable sections of Part C for employees requiring workplace accommodations on their return to work. Please fax the completed Standardized Medical Certificate to **613-596-8798**.

A Disability Management Coordinator from the OCDSB will work with your patient to support and help your patient during his/her recovery and return to work.

Confidentiality of medical information will be respected at all times. The employee's functional capabilities and / or restrictions will be shared with appropriate staff within the OCDSB.

We thank you in advance for your assistance and invite you to contact us at 613-596-8250 with any questions.

Sincerely,

Employee Wellness & Disability Management Division,
Ottawa-Carleton District School Board
613-596-8250

Attached: OCDSB Standardized Medical Certificate

OTTAWA-CARLETON DISTRICT SCHOOL BOARD
Standardized Medical Certificate
Phone: 613-596-8250 Fax: 613-596-8798

Part A - To Be Completed by Employee

Last Name: _____First Name: _____

Work location: _____EIN: _____

I will be / have been absent from work since (date) _____. I hereby consent to the completion and submission of the appropriate sections of this form by my regulated health care professional for submission in confidence to the Employee Wellness & Disability Management Division at Ottawa-Carleton District School Board.

_____ _____
Employee's Signature Date

Part B - To Be Completed by Employee's Regulated Treating Healthcare Practitioner

1. This employee sought medical attention for this illness on _____ (date)

2. This Employee is Fit to return to regular duties ☐ Date of return to work _____

3. This employee is TOTALLY DISABLED ☐

Have you discussed the possibility of a modified return to work plan with the employee? Yes ☐ No ☐

Expected date of recovery: _____Expected date of return to regular work: _____ or Modified duties: _____

Next appointment date: _____

4. Is this employee receiving ongoing treatment? : Yes ☐ No ☐
If yes, please complete the following:

i) Duration of treatment plan: _____

ii) Restrictions and/or limitations (**COMPLETE SECTION C WHERE APPLICABLE ONLY)**

iii) Expected duration of restrictions and/or limitations: _____

5. This employee is fit to return to work or remain at work with accommodations ☐
COMPLETE SECTION C ON PAGE 2 WHERE APPLICABLE

Expected duration of accommodation requirement: _____ Next appointment date: _____

6. Comments and signature section:
Provide additional comments and/or information that should be considered in order to assist in a safe and healthy return to work for your patient.

_____

_____

Healthcare Practitioner's Signature:	Date : (MM/DD/YY)
Healthcare Practitioner's Name: (Please Print)	Telephone:
Please complete and return this form to the Employee Wellness & Disability Management Officer, Employee Wellness & Disability Management Division at the Ottawa-Carleton District School Board within 3 days. Confidential Fax number is **613-596-8798**. Thank You.	

Freedom of Information Disclaimer:
Authority: The above information is collected under the authority of the Education Act (Ch.E2), Ottawa-Carleton District School Board's Disability Management Program; and when work related, the Workplace Safety and Insurance Board (WSIB).

Users:
Users of this information will be limited to the Employee Wellness & Disability Management Division of the Human Resources Department. The information will be used to assist the employee with a successful re-entry program and rehabilitation back into the workplace.

PAGE 2 PART C - TO BE COMPLETED BY EMPLOYEE'S TREATING HEALTHCARE PRACTITIONER IF ACCOMMODATIONS REQUIRES

OTTAWA-CARLETON DISTRICT SCHOOL BOARD
Standardized Medical Certificate
Phone: 613-596-8250 Fax: 613-596-8798

Part C - To Be Completed by Employee's Treating Healthcare Practitioner – if accommodations required

1. This employee is capable of:

Walking: ☐ Full abilities ☐ Up to 100 metres ☐ 100 - 200 metres ☐ Other (please specify)	**Standing:** ☐ Full abilities ☐ Up to 15 minutes ☐ 15 - 30 minutes ☐ Other (please specify)	**Sitting:** ☐ Full abilities ☐ Up to 30 minutes ☐ 30 minutes - 1 hour ☐ Other (please specify)	**Lifting from floor to waist:** ☐ Full abilities ☐ Up to 5 kilograms ☐ 5 - 10 kilograms ☐ Other (please specify)
Lifting from Waist to Shoulder: ☐ Full abilities ☐ Up to 5 kilograms ☐ 5 - 10 kilograms ☐ Other (please specify)	**Stair Climbing:** ☐ Full abilities ☐ Up to 5 steps ☐ 5 - 10 steps ☐ Other (please specify)	**Travel to Work:** Ability to use public transit ☐ Yes ☐ No	Ability to drive car ☐ Yes ☐ No

2. This employee has the following physical restrictions/limitations:

☐ Bending/twisting repetitive movement of (please specify):	☐ Work at or above shoulder activity:	☐ Chemical exposure to:	☐ Limited use of hand(s): Left / Right ☐ Gripping ☐ ☐ Pinching ☐ ☐ Other (please specify) ☐

3. Please circle the appropriate descriptor and provide any additional comments that may apply based on the cognitive demands for the employee's current position. Indicate length of time for any limitations or restrictions, where appropriate.

TASKS	COMPETENCY LEVEL				COMMENTS
	Level 1	**Level 2**	**Level 3**	**Level 4**	
Supervision Required	Needs constant supervision	Needs frequent supervision	Needs limited supervision	Requires no supervision	
Supervision of Others	Not able to supervise others	Can give direction to 1-2 staff or up to 10 students	Can give direction up to 5 staff, or up to 20 students	Can meet demands of full supervision	
Tolerance to Deadlines	Cannot deal with deadline pressures	Occasionally deal with deadlines	Can deal with deadlines that are reoccurring	Can deal with strict deadlines	
Attention to Detail	Concentration on details is severely limited	Concentration on detail is limited	Can concentrate on details, needs occasional breaks of non-detailed work	Able to concentrate intensely on detailed work	
Performance of Multiple Tasks	Can deal with one task at a time	Can handle more than 1 task but requires cues as to when to do task	Can handle multiple tasks, requires some time management assistance	Fully able to handle multiple tasks without difficulty	
Tolerance to External Stimulus	Needs quiet, non-distracting work environment	Can cope with small degree of distraction	Can cope with distracting stimuli for portion of day	Fully able to cope with multiple stimuli without negative effect	
Memory	Cannot recall recent events	Can recall remote events	Can recall recent & remote sequences & events	Can recall recent & remote complex sequences & events	
Learning	Cannot learn new skills	Can learn some new basic skills	Can learn new skills	Can learn complex new skills	
Ability to Work with Others Cooperatively	Tolerates working alone	Can tolerate others within vicinity, but needs to perform independent tasks	Can work with others cooperatively when required	Fully able to work in close cooperation with others	
Ability to Cope with Confrontational Situations	Unable to cope with confrontational situations	Can cope with exposure to confrontational situations with back-up available	Moderate ability to cope with confrontational situations	Able to deal with confrontational situations with tact and control	
Responsibility & Accountability	Errors in judgement or attention likely to occur	Can exercise a moderate level of responsibility with occasional need for support	Can accept responsibility including the responsibility for the safety of others	Can accept a high level of responsibility including sensitive situations	

Healthcare Practitioner's Signature:	Date : (MM/DD/YY)
Healthcare Practitioner's Name: (Please Print)	Telephone: