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ABILITY MANAGEMENT INC.

Christian Horizons

INJURY AT WORK PACKAGE

FOR EMPLOYEES WITH FULL-TIME OR PART-TIME PERMANENT CONTRACTS

Please complete this package if your injury resulted in medical attention, time off work or modified work/hours.

Employee Responsibilities:

- Seek immediate medical attention (family doctor, urgent care or emergency dept)
- Complete the Accident Report Form P-5:1 within 24 hours from the incident and provide to your supervisor
- Ensure medical forms are completed and forwarded accordingly for all injuries resulting in lost time or modified work.
- Your Health Care Provider may invoice Acclaim Ability Management Inc., for the completion of the enclosed medical forms through fax 1-866-486-8663
- Cooperate with our Ability Management Consultants from Acclaim Ability Management
- Participate in a safe and timely return to work
- Review Christian Horizons' Injury at Work Policy including the Role of the Employee with the Disability
- Participate in the accident investigation

Manager Responsibilities:

- Provide the employee with access to immediate medical attention (ambulance, taxi if necessary)
- Ensure the employee understands Christian Horizons' Injury at Work Policy and takes this package to their Health Care Provider (licensed physician) for their first visit
- Inform your next level manager of the injury at work
- Complete the P-5:2 Accident Investigation Report
- Send the P-5:1 Employee Accident/Occupational Illness Report, and the P-5:2 Accident Investigation Report, to Human Resources by fax to 519-650-8984 or scan to accidentreports@christian-horizons.org and to your District office.
- Send any medical documentation received to Human Resources by fax to 519-650-8984 or scan to HR Admin
- Manage the employee's attendance based on the Care Management Reports and submit P-9:9b's to HR Admin when the employee's status changes
- Work with Acclaim and the employee to facilitate a safe and timely return to work as soon as appropriate
- If needed, review the Gradual Return to Work Plan with employee

Acclaim's Responsibilities

- Receive and review all medical information
- Contact the employee via telephone and in writing, keeping them informed of the reports and status
- Provide Care Management Reports to the Manager and Human Resources with status including any return to work information or functional abilities
- Receive treatment information for paramedical expenses and approve and process payment

In this Package:

- Instructions for Employee Injured at Work
- Functional Abilities Form (to be provided to both CH and Acclaim)
- Health Professionals Report (to be sent only to Acclaim)
- Accident Report Form P-5:1

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INSTRUCTIONS TO EMPLOYEES

INJURY AT WORK FOR EMPLOYEES WITH FULL-TIME OR PART-TIME PERMANENT CONTRACTS

1. Seek immediate medical attention as needed. If more than First Aid is required, immediately go to your Family Doctor, Urgent Care or Emergency Department as appropriate.
2. Notify your Manager of the accident/incident and any health care attention related to the injury on the day you receive medical attention.
3. Complete the Accident Report form P-5:1 and provide it to your Manager.
4. Take the Functional Abilities Form (FAF) and the Health Professionals Report to the doctor and have them completed. **It is your responsibility to ensure the forms are fully completed. The Patient's Status and Task Limitations portion of the FAF must be completed.**
5. Christian Horizons has an internal insurance plan that provides specific support for employees that have been injured at work. Christian Horizons does not subscribe to WSIB insurance. Please ensure that your Health Care Provider understands they will be compensated for the completion of the enclosed forms by Acclaim Ability Management Inc using WSIB guidelines.
6. If your accident results in a Lost Time injury and/or requires Modified work (Limitations as Specified), have the FAF and Health Professionals Report faxed to Acclaim via confidential fax # 1-866-486-8663, immediately or prior to your next shift.
7. **If you require modified work (Limitations as Specified), bring your completed FAF to your supervisor Manager prior to or for your next scheduled shift.**
8. Fax the Accident Report and completed FAF to Human Resources at 519-650-8984. Do not bring or send the Health Professionals Report to anyone other than Acclaim.
9. An Ability Management Consultant (AMC) from Acclaim will contact you within 1 to 2 business days from the receipt of your Health Professionals Report or following a referral from Christian Horizons indicating that you have had an injury at work resulting in absence or modified work.
10. The Acclaim AMC will provide you with updates on the phone and in writing regarding the status of your injury at work leave of absence.
11. Gradual modified work or hours will be made available to you immediately.
12. As you recover, you are required to be under the care of a Regulated Health Professional and actively participate in treatment to promote recovery.
13. Provide medical updates on your condition to Acclaim as requested.
14. Work with Acclaim and Christian Horizons as they provide you with a safe and appropriate return to work based on the medical information received.
15. Be responsible for working within the limitations of the return to work plan.

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Functional Abilities Form (FAF) for Safe & Timely Return to Work
Injury at Work for Employees with Full-Time OR Part-Time permanent contracts

TO BE COMPLETED BY EMPLOYEE

Employee Name ______________________ Day Phone # (s) ______________________

Job Title ______________________ Work Location ______________________

AUTHORIZATION FOR RELEASE OF INFORMATION

By signing below, I hereby authorize heath care provider(s) or institutions involved in my treatment to provide all information and documents requested by Acclaim Ability Management Inc. including LTD Carrier and Disability Management Consultants, concerning my medical or behavioural health condition. This authorization is valid from the date hereof through the date of return to work to full duty. All information will be treated in a highly confidential manner. Information regarding my restrictions/limitations will be shared with my supervisors. I agree that facsimile copy or a Photostat copy is to be considered effective as an original signed copy.

I understand that Modified work is available immediately. If return to modified duties is indicated, I am to report to work for my next scheduled shift with this completed form in hand.

Next Scheduled Shift Date(s): | | | | | | **Number of Contract Hours per Week:** ______________

______________________ ______________________ ______________________
Employee Name (Printed) Employee Signature Date

TO BE COMPLETED BY LICENCED PHYSICIAN

Please indicate the Patient's Status and Task Limitations in relation to the Health Professional's Report.

- ☐ No Limitations = No Lost Time & Return to Work (Complete Health Professional's Information Section Below)
- ☐ Limitations As Specified = Return to Modified Duties (Complete Capabilities and Health Professional's Section Below and Health Professional's Report)
- ☐ Lost Time = No Return to Work (Complete Capabilities and Health Professional's Section Below and Health Professional's Report))

CAPABILITIES:

Walking (continuously):	☐ up to 20 min;	☐ up to 1 hour;	☐ no restriction;	☐ Other (e.g. uneven ground) ______	
Standing (continuously):	☐ up to 20 min;	☐ up to 1 hour;	☐ no restriction;	☐ Other ______	
Sitting (continuously):	☐ up to 30 min;	☐ up to 1 hour;	☐ no restriction;	☐ Other ______	
Lifting floor to waist:	☐ up to 20 lbs;	☐ up to 30 lbs	☐ up to 40 lbs;	☐ no restriction;	☐ Other ______
Lifting waist to shoulder:	☐ up to 20 lbs;	☐ up to 30 lbs	☐ up to 40 lbs;	☐ no restriction;	☐ Other ______
Stair climbing:	☐ unable;	☐ 2-3 steps only;	☐ own pace;	☐ assisted;	☐ no restriction
Patient is:	☐ Left handed;	☐ Right handed;	☐ Ambidextrous		
Limited ability to used **left** hand to:		☐ hold objects;	☐ grip;	☐ type;	☐ write
Limited ability to used **right** hand to:		☐ hold objects;	☐ grip;	☐ type;	☐ write
Completely unable to use **left** hand to:		☐ hold objects;	☐ grip;	☐ type;	☐ write
Completely unable to use **right** hand to:		☐ hold objects;	☐ grip;	☐ type;	☐ write

Hours per day: ☐ 4 hours; ☐ 6 hours; ☐ 8 hours; ☐ no restriction; ☐ less then 4 hours (specify) __________

Explanation/Barriers to Return to Work/Additional Details: ______________________________________

These limitations will apply for:_____(# of days/ weeks) Full duties date:______________ Follow up appointment date: ___________ or none required ☐

Have you discussed return to work with above limitations with your patient? ☐ Yes ☐ No

By completing this Functional Abilities Form, the information contained herein will become part of the employee health file and may be accessed by the patient, the LTD Insurance carrier, third party administrator, or other health care professionals, as applicable.

HEALTH PROFESSIONAL'S INFORMATION SECTION:

Physicians name (please print): ______________________ Speciality: ______________________

Address: ____

Telephone: ______________________ Fax: ______________________

Signature: ______________________ Date: ______________________

Please fax completed form and invoice directly to ***ACCLAIM Ability Management Ltd.*** at 1-866-486-8663 with Health Professional's Report.

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Christian Horizons

Health Professional's Report for Injury at Work

CONFIDENTIAL

Christian Horizons has an internal insurance plan that provides specific support for employees that have been injured at work. Christian Horizons does not subscribe to WSIB insurance. Health Care Providers will be compensated for the completion of the enclosed forms by Acclaim Ability Management Inc using WSIB guidelines.

SECTION A: TO BE COMPLETED BY EMPLOYEE

Employee's Name ______________________________ Sex: M ___ F ___
(Last name first, in full)

AUTHORIZATION

By signing below, I hereby authorize heath care provider(s) or institutions involved in my treatment to provide all information and documents requested by Acclaim Ability Management Inc. including LTD Carrier and Disability Management Consultants, concerning my medical or behavioral health condition. This authorization is valid from the date hereof through the date of return to work to full duty. All information will be treated in a highly confidential manner. Information regarding my restrictions/limitations will be shared with my supervisors. I agree that facsimile copy or a Photostat copy is to be considered effective as an original signed copy.

______________________ ______________________ ______________________
Employee Name (Printed) Employee Signature Date

SECTION B: HEALTH PROFESSIONAL'S INFORMATION

Physician's name (please print): ______________________ Speciality: ______________________

Address: ______________________

Telephone: ______________________ Fax: ______________________

SECTION C: INCIDENT DATES AND DETAILS

1. Are you this patient's primary Health Professional: ☐ Yes ☐ No
2. Have you treated this patient in the past for this injury? ☐ Yes ☐ No

   If yes, please list dates of treatment since your last report below:

   ____
3. What is your understanding of how this injury or re-injury occurred? Yes ☐ No
4. Is this injury work related? Yes ☐ No

Date of Accident	dd	mm	yyyy
Date of Assessment	dd	mm	yyyy
Location of Assessment	☐Emergency	☐Office	
	☐Walk-in-clinic	☐Workplace	
	☐Other ______		

5. Area of Injury, check all that apply:

Location	Body Part				Injury
☐ right	☐head	☐ arm	leg	☐ hip	☐ strain
☐ left	☐ face	☐ shoulder	☐ calf	☐ back	☐ abrasion
☐ upper	☐brain	☐elbow	☐ankle	☐ abdomen	☐ sprain
☐ lower	☐ eyes	☐ forearm	☐ thigh	☐ chest	☐ fracture
☐n/a		☐ finger	☐knee		☐ bruise
		☐ hand	☐ heel		☐ laceration
☐ ears		☐ wrist	☐foot		☐burn
☐ teeth			☐ toe		☐ puncture
☐ neck	☐ other specify:				☐ pull
☐ chest					☐tear

Please fax completed form and invoice directly to ***ACCLAIM Ability Management Ltd.*** at **1-866-486-8663**.

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Christian Horizons

Health Professional's Report for Injury at Work

CONFIDENTIAL

		☐ other specify:

6. Patient's Present Complaints (subjective complaints):

7. Physical Examination (objective findings):

8. Are there abnormal signs for any of the following:

Active ROM Passive ROM Gait
Strength Sensation Reflexes Other

If so, please describe:

9. Are you aware of any pre-existing or other conditions that may delay recovery? ☐ Yes ☐ No

10. Diagnosis/ Working Diagnosis:

SECTION D: TREATMENT PLAN AND RETURN TO WORK INFORMATION

1. Treatment Plan
Provide your proposed treatment plan for this patient
(Include goals, duration, frequency, etc.)

2. Medication(s) Prescribed
Provide prescription details and anticipated medication
Adverse effects that could possibly impact ability to Return to Work.

3. Assistive Devices Prescribed
Provide details (crutches, orthotic supports, etc.)

Treatment Plan/ Medication Details:

4. Investigation and Referrals:

☐ None ☐ Labs ☐ X-Rays ☐ MRI ☐ CT Scan ☐ EMG/NCS ☐ Other

☐ Family Physician ☐ Specialist Name: ____________________

☐ Chiropractor ☐ Massage Therapist ☐ Occupational Health Centre

☐ Physiotherapist ☐ Occupational Therapist ☐ Other: ____________

Name of Referral/Facility (if known):____________Telephone: ____________Appointment Date: ____________

5. Return to work information Have you discussed return to work with your patient? ☐ Yes ☐ No

Return to work to modified duties Date:____________

Return to work to full duties Date: ____________ Date of next Assessment: ____________

I hereby declare that the information being submitted is true and complete.

Physician's name (please print): ____________________

Signature: ____________________ Date: ____________

Please fax completed form and invoice directly to ***ACCLAIM Ability Management Ltd.*** at **1-866-486-8663.**

ChristianHorizons

ACCIDENT/INCIDENT/OCCUPATIONAL ILLNESS/ NEAR MISS REPORT

This form must be submitted within 24 hours of the incident.

This form is to be completed by the employee immediately after an incident *(please print using black ink and print clearly if handwritten)*

Last Name: First Name:

Employee #: Position:

Program Name and #:

Date Of Accident: Time (2400):

Date Reported to Supervisor: Time (2400):

Location of Incident:

Was a person supported involved? ☐ Yes ☐ No

Did the incident/injury occur during the application of restraints? ☐ Yes ☐ No

Witnesses (people present at time of accident):

State the incident including sequence of events leading up to the Incident:

TYPE OF INCIDENT

- ☐ Struck By or Contact With
- ☐ Caught In/On or Between
- ☐ Fall/Slip
- ☐ Over Exertion/Strain
- ☐ Exposure/Environmental
- ☐ Occupational Illness
- ☐ Sharps/Needle Stick
- ☐ Fire/Explosion
- ☐ Violence/Assault
- ☐ Motor Vehicle Accident
- ☐ Near Miss*
- ☐ Other: ______

*If you are reporting a near miss, was it due to: ☐ Unsafe Act ☐ Unsafe Condition ☐ Unsafe Equipment

Indicate type of injury, part of body involved and specify right or left side (below):

INJURY TO: (L= Left / R= Right)	**L**	**R**
☐ Face or Head	☐	☐
☐ Eye/Ear	☐	☐
☐ Upper Back	☐	☐
☐ Lower Back	☐	☐
☐ Neck / Shoulder	☐	☐
☐ Arm / Wrist	☐	☐
☐ Hand / Fingers	☐	☐
☐ Leg	☐	☐
☐ Toe / Foot	☐	☐
☐ Abdomen	☐	☐
☐ Chest	☐	☐
☐ Other: ______	☐	☐

TYPE OF INJURY:

- ☐ Laceration
- ☐ Strain / Sprain
- ☐ Bruise(s)
- ☐ Fracture
- ☐ Puncture
- ☐ Abrasion
- ☐ Amputation
- ☐ Burns
- ☐ Foreign Body
- ☐ Skin
- ☐ Exposure
- ☐ Other: ______

TREATMENT *(Must choose one)*:

- ☐ On-site First Aid Only
- ☐ Hospital Emergency Dept.
- ☐ Doctor's or Other Professional Care
- ☐ None

CLAIM TYPE *(Must choose one)*:

- ☐ Lost Time From Work (missed next shift)**
- ☐ No Lost Time From Work (did not miss next shift)
- ☐ Near Miss*
- ☐ Critical Injury - **Reported to Ministry of Labour**

Have you had a similar injury or disability? ☐ Yes ☐ No If yes, explain:

**If you lost time, when did you leave work? Date: Time (2400):

(Injury at Work – IAW package must be completed for lost time claims)

Please provide recommendations to prevent recurrence:

Employee Signature: ______________________ Date: ______________

Supervisor's Signature: ______________________ Date: ______________

DISTRIBUTION: Forward to the appropriate locations within 24 hours

1. Email: accidentreports@christian-horizons.org or Fax: 519-650-8984
2. Immediate Supervisor
3. District Office/Corporate Office Manager
4. Health and Safety Representative/Joint Health & Safety Committee