acclaim
ABILITY MANAGEMENT INC.

ChristianHorizons

PERSONAL MEDICAL LEAVE (PML) & WORK ACCOMMODATION PACKAGE

FOR EMPLOYEES WITH FULL-TIME OR PART-TIME CONTRACTS;
BOTH PERMANENT AND TEMPORARY

Employee Responsibilities:

- Familiarize yourself with the enclosed package
- Provide requested medical documentation in a timely manner
- Cooperate with our Ability Management Consultants from Acclaim Ability Management
- Participate in a safe and timely return to work
- Review Christian Horizons' Policy for Personal Medical Leave including the Role of the Employee with the Disability

Manager Responsibilities:

- Notify Human Resources (Benefits Specialist) as soon as you are aware of any of the following situations:
  - An employee who knows they will be off due to illness/injury for more than 10 consecutive shifts, e.g., surgery with a 4 week recovery period
  - An employee who has been off due to illness/injury and their leave goes beyond 10 consecutive shifts
  - An employee who has taken all of their Personal Emergency Leave (PEL) time available but has time in their PML bank and is requesting pay for any Personal Medical Leave of 4 consecutive shifts or more, due to illness/injury
  - An employee who requests any type of work accommodation due to illness/injury (modified duties and/or hours)
- Forward a P-9:9b to HR Admin and any medical documentation received to Human Resources by fax to 519-650-8984 or scan to HR Admin. *Attending Physician's Statement not to be received by CH.*
- Assist your employee in understanding Christian Horizons' Personal Medical Leave Policy
- Provide modified work for your employee as they work toward full duties
- If necessary, prepare a Physical Demands Analysis Form for Acclaim to assist in understanding your employee's specific job duties
- Manage the employee's attendance based on the Care Management Reports and submit P-9:9b to HR Admin when the employee's changes
- Keep in touch with your employee to support them as they recover
- If appropriate, 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

In This Package:

- Instructions for Employee
- An Attending Physician's Statement Form to be fully completed by a licensed physician and faxed directly to Acclaim at 1-866-486-8663 toll free

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INSTRUCTIONS TO EMPLOYEES

PERSONAL MEDICAL LEAVE (PML) & WORK ACCOMMODATION FOR EMPLOYEES WITH FULL-TIME OR PART-TIME CONTRACTS; BOTH PERMANENT AND TEMPORARY

1. Should your absence be longer than **10 consecutive shifts**, OR you have taken all of your Personal Emergency Leave (PEL) time available but have time in your PML bank and would like pay for any Personal Medical Leave of 4 consecutive shifts or more, due to illness/injury, a fully completed Attending Physician's Statement Form is required.
2. Should you require any type of work accommodation (modified duties and/or hours), due to illness/injury, a fully completed Attending Physician's Statement Form is required.
3. Take the Attending Physician's Statement (APS) form to your doctor for completion and fax the completed APS form to Acclaim at 1-866-486-8663 (toll free) from your doctor's office or another location available to you. If needed, you may fax from your work location.
4. An Ability Management Consultant (AMC) from Acclaim will contact you within 1 to 2 business days from the receipt of your APS or following a referral from Christian Horizons indicating that you have requested a personal medical leave.
5. The Acclaim AMC will provide you with updates on the phone and in writing regarding the status of your personal medical leave.
6. As you recover, you are to actively take part in treatment in order to facilitate your return to work to your regular position.
7. Christian Horizons will provide transitional modified work if you require it, in order to assist in your safe return to work.
8. **If you require modified work, bring the doctor`s completed Capabilities Information (Section B) to your supervisor Manager prior to or for your next scheduled shift.**
9. Participate in providing medical updates on your condition to Acclaim whenever you are asked to do so.
10. Work with Acclaim and Christian Horizons as they provide you with a safe and appropriate return to work based on the medical information received.

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Attending Physician Statement (APS)
For Personal Medical Leave (PML) & Work Accommodation

In order to support a Personal Medical Leave and/or a Work Accommodation for this employee and to facilitate his/her return to work we require specific information. Christian Horizons' is committed to providing a transitional/modified work program for its personnel and we require your guidance to ensure a timely and safe return to work. ACCLAIM Ability Management Inc. and Christian Horizons co-ordinate these efforts in collaboration with the primary care provider, manager/supervisor and worker. ***All costs associated with the completion of this form are the responsibility of the employee.***

TO BE COMPLETED BY EMPLOYEE

Employee's Name_____ Phone No._____
(Last name first, in full)

Address_____|_|_|_|_|_|_|
(Street Number and Name) (Apt. No.) (City/Town) (Province) (Postal Code)

Date of Birth: |_|_|_|_|_|_|_|_|_|_| Language: E ___ F ___ Other ___ Sex: M ___ F____

AUTHORIZATION
I do, hereby authorize _____ (healthcare provider, licensed physician, medical practitioner, hospital, clinic) to disclose my medical and health information to ACCLAIM Ability Management Inc, which includes any independent evaluators, agents and consultants acting on behalf of ACCLAIM.

This consent pertains to my current absence from work and/or my need for modified or accommodated work, and/or the current referral to ACCLAIM Ability Management Inc for services. These services may include the results of consultations or assessments obtained regarding my health condition. I authorize ACCLAIM Ability Management Inc to release information to Christian Horizons' LTD carrier and/or other involved health care practitioners.

I understand that the aforementioned communication and information, portions thereof, and/or resulting recommendations that relate to my abilities or limitations to perform my job duties (excluding specific reference to diagnosis or related personal information) may be communicated to Christian Horizons for the purposes of any one or more of the following:

1. Accommodating for my health condition with Christian Horizons;
2. Providing information for modified work with Christian Horizons;
3. Validating or authorizing an absence from work;
4. Determining my eligibility for benefits; and/or
5. Managing my return to work with the Christian Horizons

A photocopy or facsimile of this authorization shall be as valid as the original.

By signing below I consent to collection, use and disclosure of my personal information, including my health information, for the purposes as described above. I am aware that I can choose to provide or withhold this consent, but that may affect my eligibility for benefits through the Christian Horizons' Short Term Disability Benefits plan.

This consent is valid from the date signed until I return to full hours and duties at work, or on the date my business relationship with Christian Horizons has been formally severed, whichever is earlier. It may be withdrawn at any time if I provide prior written notification to ACCLAIM or to Christian Horizons.

_____ _____ _____
Employee Name (Printed) Employee Signature Date

SECTION A: ILLNESS / INJURY INFORMATION (To be completed by licensed Physician)

Nature of the Illness/Injury: _____

Date Illness/Injury Began: _____ Date of Examination by Physician: _____

Is this Illness/Injury work related: □ Yes □ No

Anticipated Length of Illness/Injury: _____ Date Patient Expected to Return to Full Duties: _____

Has a Follow Up Appointment been Scheduled: □ Yes □ No If ***yes***, when: _____

Has a Treatment Plan been Prescribed to the Patient: □ Yes □ No
If ***no***, please explain why: _____

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

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Is the Patient Compliant with treatment: □ Yes □ No

If the Patient cannot Return to Full Duties, can they Return to Work on Modified Duties: □ Yes □ No
If ***no***, please explain the medical contraindications: _____

Complete SECTION B below regarding the patient's restrictions and limitations that resulted in the current absence and/or need for modified duties

SECTION B: CAPABILITIES INFORMATION

Expected Length of Time Modifications will be Required: _____

FUNCTIONAL ABILITIES:

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) _____

COGNITIVE ABILITIES:

COGNITIVE RESTRICTIONS AND LIMITATIONS

Sustain Concentration:	☐ No Limitation	☐ Specify details: _____
Interact with Others:	☐ No Limitation	☐ Specify details: _____
Process Instructions:	☐ No Limitation	☐ Specify details: _____
Driving:	☐ No Limitations	☐ Specify details: _____
Restrictions due to medication:	☐ None	☐ Specify details: _____

Additional Comments/Accommodations Required:

_____

_____

SECTION C: ATTENDING PHYSICIAN'S INFORMATION

Physicians name (please print): _____ Speciality: _____

Address: _____

Telephone: _____ Fax: _____

Signature: _____ Date: _____

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