IN THE MATTER OF AN ARBITRATION
Pursuant to the *Labour Relations Act,* R.S. 1995

BETWEEN:

THE OTTAWA HOSPITAL

("Employer")

- and –

OPSEU, LOCAL 464

("Union")

(Grievances 2017-0464-0039 and 2017-0464-0040)

SOLE ARBITRATOR: Jasbir Parmar

On Behalf of the Employer:

J.D. Sharpe

On Behalf of the Union:

Jean-Michel Corbeil

This matter was heard on October 11, 2019 in Ottawa.

[1] I was appointed by the parties to hear and determine two grievances, #2017-0464-0039 and #2017-0464-0040.

[2] It was agreed that I would address #2017-0464-0039 first. The issue in dispute in this grievance, at its most basic, is the employer's use of the Attending Practitioner's Statement Report (APSR) in the context of the Medical Leave Corporate Policy.

[3] Having heard the submissions of the parties, I have determined the Employer may use the attached APSR form.

Dated this 15th day of October, 2019.

"Jasbir Parmar"

JASBIR PARMAR

The Ottawa Hospital | L'Hôpital d'Ottawa

ATTENDING PRACTITIONER'S STATEMENT REPORT

In application for sick leave benefits or to support a work absence, please ask your attending health-care professional to complete sections 2 **and 3** of this form.

This information is vital to ensure eligibility to benefits during absence from work. **You are obligated to provide OHW with updates concerning your prognosis and your abilities as they relate to your job tasks. This initial report shall be provided to OHW in a timely manner, but ideally within 48 hours of any medical assessment. If you are aware of any delays in obtaining the information requested, you must inform OHW promptly and must facilitate ongoing communication to assist in your successful return to work.**

If your illness or injury is a result of a workplace incident, **do not use this form.**

SECTION 1: To be completed by the employee

Last name	First name	Date of birth (yyyy/mm/dd)
Date of injury / illness (yyyy/mm/dd)		
Employment status ❑ FT ❑ PT ❑ Casual	Practitioner's name	

Employee Consent

I authorize the practitioner who has provided care to me during my current injury/illness to complete this form. I have read and agree to abide by my responsibilities outlined in the medical leave policy (No. 00264). **I understand that failure to sign this consent may impact access to sick leave benefits.**

Employee signature	Date (yyyy/mm/dd)

SECTION 2: To be completed in full by the attending health-care professional or it may be considered incomplete

First date of assessment (yyyy/mm/dd)	**First date of absence (yyyy/mm/dd)**	Next date of assessment, if applicable (yyyy/mm/dd)

1. Please identify the nature (but not diagnosis) of the current injury/illness causing absence from work? (e.g., communicable disease, musculoskeletal injury, **mental health**, etc.). If more than one, please indicate.

   _____

2. **Is the employee under an active treatment plan? ❑ Yes ❑ No**
   a. Is the employee actively participating in the recommended treatment plan? ❑ Yes ❑ No
   b. Is there further follow-up required or planned with respect to the treatment plan? ❑ Yes ❑ No

3. Is the employee under treatment which may impair his/her judgement or ability to work safely? ❑ Yes ❑ No

4. **Is the information that you are providing based on an in-person examination of the patient and your application of any related tests or assessment tools? ❑ Yes ❑ No**

5. Has the employee missed work for the same or related condition in the past? ❑ Yes ❑ No ❑ **Unknown**

6. **Based on your assessment, what is the anticipated date of return to work with or without ongoing medical restrictions:** (yyyy/mm/dd)_____. **Complete section 3 on the second page.**

7. Is this a provincially insurance paid procedure? (Ex: OHIP or RAMQ) ❑ Yes ❑ No ❑ N/A

SECTION 3 To be completed in full by the attending health-care professional or it may be considered incomplete

TOH supports a modified work program that promotes an employee's safe and healthy return to work (e.g., progressive gradual return to work hours; modified duties; additional support).

CURRENT PHYSICAL ABILITIES			<1 hr	1-2 hrs	2-4 hrs	5-6 hrs	>6 hrs
Sitting	❑ Full abilities	❑**No abilities**	❑	❑	❑	❑	❑
Standing	❑ Full abilities	❑**No abilities**	❑	❑	❑	❑	❑
Walking	❑ Full abilities	❑**No abilities**	❑	❑	❑	❑	❑
Stair Climbing	❑ Full abilities	❑**No abilities**	❑	❑	❑	❑	❑
Movements	❑ Full abilities		❑ No sustained forward Flexion	❑ No overhead or extended arm reach	❑ No bending or twisting	❑ No repetitive or sustained use of:	❑ No work below waist
Pushing/Pulling (kg)	❑ Full abilities		❑ No push	❑ No Pull			
Lifting/Lowering (kg)	❑ Full abilities		❑ No lifting / lowering	❑ <5	❑ 5-10	❑ 11-20	❑ 11-20

CURRENT COGNITIVE RESTRICTIONS

If applicable, please comment.

Please indicate anticipated duration of medical restrictions listed above: (yyyy/mm/dd) - (yyyy/mm/dd) _____

ANY ADDITIONAL COMMENTS

Thank you for completing this report.

The information provided will assist your patient in returning to work as soon as possible. Please note that medical leave benefits will be payable as soon as this form is received and accepted by OHW.

Practitioner name	Signature	Date (yyyy/mm/dd)
License number	Fax	Phone
Address		

❑ **Civic Campus**
1053 Carling Avenue
Ottawa, ON K1Y 4E9
Fax: 613-761-4162
Tel: 613-798-5555 x14161

❑ **General Campus**
501 Smyth Road
Ottawa, ON K1H 8L6
Fax: 613-737-8912
Tel: 613-737-8899 x78391

❑ **Riverside Campus**
1967 Riverside Drive
Ottawa, ON K1H 7W9
Fax: 613-738-8260
Tel: 613-738-8400 x88250

Or by e-mail marked "Confidential" to: OccupationalHealth@toh.ca

Please note that any fee for the completion of this form is the responsibility of the employee.
TOH will reimburse the employee, as per the Medical Leave Policy