lifemark HEALTH GROUP

## DISABILITY/SICK LEAVE
## ATTENDING PHYSICIAN'S STATEMENT

**Please complete this form in full and fax directly to 1-403-569-0196**

**Alternatively, you may send via mail to:**
**Lifemark Disability Management**
**Suite 70, 2121 Street NE Calgary, Alberta T1Y 7H8**

**Physician's Letter**

To Whom It May Concern:

The University of Saskatchewan has an active Disability Management Program. In an effort to assist the University of Saskatchewan employees with their rehabilitation and help them to remain connected to the workplace, they have partnered with Lifemark Health.

The University of Saskatchewan's work accommodations are designed to be meaningful and tailored to meet your patient's/their employee's rehabilitation needs. For example, they offer flexible, graduated return to work opportunities whereby the employee works the number of hours that they are able to tolerate as they progress towards recovery. The goal is to safely return employees to their own jobs as soon as possible.

The Disability Management Program requires cooperation between the University of Saskatchewan, Lifemark Health, your patient and of course, you. Your patient has been asked to provide you with the attached information, which includes an Attending Physician Statement in order to assist with the determination of his or her illness or injury. Once it has been determined the employee is fit to return to work, Lifemark Health will work with the patient to obtain an updated Attending Physician Statement that is specific to the patients functional abilities and return to work plan.

Please note that Lifemark Health follows the CMA/SMA positions in support of timely return to work and the role of the physician. These positions generally identify that:

*The physician should provide an accurate and objective assessment of impairment and provide validated restrictions and limitations.*

Your cooperation in providing this information is appreciated. It assists the University of Saskatchewan to provide income continuance for your patient and will assist the University of Saskatchewan greatly in their support of this employee. Please fax the information directly to Lifemark Health at 403-569-0196. Please ensure your patient has signed the enclosed Consent for release of medical information.

Please note that cost for the completion of the form is the responsibility of the employee and the return of the medical form is time sensitive in order to continue benefits. We look forward to working with you to assist in your patient's recovery and return to work.

Thank you in advance for your assistance and cooperation.

Regards,

Lifemark Health Team

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| **Employee Name:** | **Employee Birthdate:** |
|---|---|
| **Medical Information** | |
| **Are you the primary physician for this patient?**<br>**Yes ☐ No ☐** | **Is condition due to injury or illness arising out of patient's employment?**<br>**Yes ☐ No ☐** |
| **Date when illness or injury first commenced:**<br>**Date:** ______________________<br>Month / Day / Year | **Date of your first review for this current illness or injury:**<br>**Date:** ______________________<br>Month / Day / Year |
| **Will there be medical follow-ups?**<br>**Date:** ______________________<br>Month / Day / Year | **Are there non-medical factors contributing to this absence? If so, are they being addressed (i.e. EAP)?** |
| **Describe current limitations and capabilities:** | **Effect of observed limitations on employee's ability to attend work and/or perform regular work duties:** |
| **Prognosis for recovery from limitations, and estimated return to work date in any capacity:**<br><br>**Estimated duration of absence:** | **Is your information based on subjective or objective reports? Please comment:** |
| **Return to Work/Stay at Work** | |
| **The employee can engage in a modified work plan effective: (date)** | **Medically able to resume and/or continue**<br>**Full work _____**<br>**Or modified work _____** |

| | |
|---|---|
| PHYSICIAN'S NAME | SPECIALITY |
| | |
| PHYSICIAN'S SIGNATURE<br>*I verify that Part 1 of this form has been reviewed and completed* | DATE |

**Physician / Office Address Stamp (required)**

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