Occupational Health and Employee Wellbeing

Medical Absence Form

Employee name

Employee number

Phone number

Email address

Work location/Cost Centre

First day sick

Return to work date, if known

Have you been in contact with your treating doctor, Telehealth or Public Health Unit? ☐ Yes ☐ No
If YES, on what date?

Do you have medical documentation to support this absence? From either Public Health Unit or your treating medical practitioner. ☐ Yes ☐ No

Is your absence **COVID related**? ☐ Yes ☐ No
If YES, please report on the following:

- Do you have a new or worsening cough, fever, shortness of breath, or other symptoms consistent with a respiratory infection? ☐ Yes ☐ No
- Date symptoms began:
- Were you at work when your symptoms started? ☐ Yes ☐ No
- Were you at work 48 hours prior to onset of symptoms? ☐ Yes ☐ No
- Have you completed the online Ontario Ministry of Health self-assessment tool? (covid-19.ontario.ca) ☐ Yes ☐ No
  If YES, what was the result:
- Are you currently in self-isolation? ☐ Yes ☐ No
  If YES, beginning on what date?
- Have you had contact with someone who has tested positive for COVID? ☐ Yes ☐ No
- Have you or someone you are in close contact with recently travelled? ☐ Yes ☐ No
- Have you been in contact with someone who has new respiratory symptoms? ☐ Yes ☐ No
- Are you **currently** medically well but self-isolating out of precaution due to your age and/or a pre-existing medical condition (e.g. immunocompromised)? ☐ Yes ☐ No

If your absence is **not related to COVID**, what is the reason for absence?

Is your absence related to an ongoing medical condition?..... ☐ Yes ☐ No

If YES, please explain:

What is the recommended treatment plan prescribed by your treating doctor (Medications, physiotherapy, psychotherapy, etc.)?

What are your restrictions and limitations, if any?

Duration of restrictions/limitations:

I certify that the information given on this form is true, correct and complete. I hereby authorize and direct the TTC Occupational Health and Employee Wellbeing (OHEW) department, any licensed physician, health care professional, hospital, clinic, or other medical or medically-related facility, insurance company, to share and exchange all relevant information and medical documentation, for the purpose of administering this claim and facilitating my return to work. I hereby acknowledge that I will not engage in activity(ies) contrary to my doctor's treatment plan, in order that I shall remain in good standing with the applicable benefits plans. I acknowledge that I must notify OHEW immediately of any changes to my medical condition(s), level of disability, and/or ability to return-to-work. I also acknowledge that I may be required to provide proof of medical documentation to support this absence at a later date. This authorization shall remain valid for the duration of my claim for benefits. A reproduction of this authorization shall be as valid as the original, for managing this claim. I understand that I can revoke this authorization at any time but that without it my claim cannot be assessed.

Employee Signature

Date

OR IF COMPLETING ELECTRONIC VERSION OF THIS FORM CHECK BOX:

☐ I affirm that entering my badge number below and submitting this form constitutes an electronic signature of this form.

Badge Number

Date

Please save and send form to: OHEW@ttc.ca

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