EMPLOYEE ATTENDANCE SUPPORT PROGRAM
SERIOUS CHRONIC CONDITION EXCLUSION REQUEST FORM

Absences arising out of a medically established **serious chronic condition** will not be counted for the purposes of being placed on, or progressing through, the steps of Headwaters Health Care Centre Employee Attendance Support Program.

A **serious chronic condition** is defined as a medically established (through objective testing, imaging, etc.) long-term disease that develops slowly over time, often progressing in severity, and can often be controlled, but rarely cured. The term "serious" is applicable to a chronic medical condition that despite optimal treatment causes the individual temporary or permanent disability which impacts activities of daily living, including performing some or all of the essential job duties. A serious chronic medical condition requires ongoing treatment/consultation with an appropriate treating specialist. Dates of absence due to temporarily disability caused by serious chronic condition supported by proper medical documentation (**from treating specialist**) will not be counted towards the Attendance Support Program. The employee must also be compliant with their practitioners recommended treatments (e.g. medications, diet, exercise, etc.). Treating specialist may be a practitioner specializing in a particular class of patients (e.g. family medicine, pediatrics) or of diseases (e.g. rheumatology, endocrinology) or technique (e.g. orthopedic surgeon, ophthalmology).

Part 1: EMPLOYEE AUTHORIZATION

Employee Name (please print): ____________________

I hereby authorize my attending physician to complete this Exclusion Request Form specifically in reference to my serious chronic condition:

Patient Signature: ____________________ Date:___/___/_____(dd/mm/yyyy)

Part 2: ATTENDING PHYSICIAN INFORMATION (Use reverse if insufficient space below)

Your patient has indicated that they are periodically totally disabled and unable to attend work related to a serious chronic condition (see definition above). Please answer the following questions based on your objective medical opinion and assessment:

a. Does your patient have a medically established serious chronic condition that may impact ability to work?..... YES ☐ NO ☐
b. Please provide what the serious chronic condition is based on the above definition…………
c. When was your patient first diagnosed with the serious chronic condition? …………
d. How often is your patient reassessed in regards to the serious chronic condition?…………
e. Prior to today, when were they last assessed?…………
f. Was your patient assessed and diagnosed by a practitioner specializing in the diagnosed condition?...... YES ☐ NO ☐
g. What testing was done to diagnosis serious chronic condition?…………
h. Is your patient compliant with recommended treatments and follow up appointments?…………YES ☐ NO ☐
i. Does ongoing treatment side effects result in periodic inability to perform essential duties of job?.. YES ☐ NO ☐ N/A ☐
j. What is the current state of the condition?………… STABLE ☐ UNSTABLE ☐

Part 3: ATTENDING PHYSICIAN AUTHORIZATION

I certify that, in my opinion, the above statement(s) accurately confirms that my patient has a medically established serious chronic condition that may periodically affect their ability to perform the essential duties of their job and are an accurate representation of my actual treatment/medical notes.

MD Signature	Office Stamp (required for validation)
MD Name	
Date	
Address & Telephone	

Once completed, please return this form via FAX or EMAIL to Occupational Health and Safety Fax: 519-941-2342 or Email: occhealthandsafety@headwatershealth.ca

Please provide additional information below