YORK
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Medical Absence/Accommodation Certificate (MAAC)

PLEASE RETURN COMPLETED FORM TO HEALTH, SAFETY & EMPLOYEE WELL-BEING (4700 KEELE ST. TORONTO ON M3J 1P3)
CONFIDENTIAL FAX: (416) 736-5439

Part A: Academic/Non-Academic Employee Identification and Authorization

Name (last, first): ______________________ **First Day Absent:** ____________

Home Address: ______________________ **Home Telephone:** ____________

Occupation: ______________________ **Status:** ☐ FT ☐ PT ☐ Sessional ☐ Contract ☐ Affiliation:______

Immediate Manager or Dean: ______________________ **Department/Faculty:** ____________

I hereby authorize the practitioner to complete and sign this form. This information provided is for the sole purpose of determining my fitness to work and/or the need for any accommodations in my workplace and/or substantiating my absence due to illness or injury and/or eligibility for benefits.

Academic/Non-Academic Employee Signature (MANDATORY):	**Date:**

All medical information received will be kept in strict confidence in the employee's medical file at the offices of Health, Safety & Employee Well-Being (HSEWB).

Part B: Attending Practitioner's Report (to be completed ONLY by the Practitioner)

PLEASE SEE ATTACHED INSTRUCTION SHEET FOR CLARIFICATION ON INFORMATION REQUIRED

*The Ontario Medical Association (OMA) outlines in its "***Position in Support of Timely RTW Programs and the role of the Practitioner***", that practitioners should provide* ***objective*** *reports on* ***impairment****, medical restrictions and other supporting advice to Academic/Non-Academic employees. Upon receipt of this information,* ***YORK UNIVERSITY*** *will offer, as necessary, a modified or graduated, "Return to Work" program, time limited (normally 4 – 6 weeks) designed to facilitate the timely and safe return of Academic/Non-Academic employees who are recovering from injury or illness.*

I. Absence/Accommodation due to: ☐ Illness ☐ Injury

II. Nature of Illness/Injury (disclosure of diagnosis is not being requested): ____________

III. Does the current illness or injury involve any of the following:

a) ☐ A communicable disease reportable to Public Health **c)** ☐ Workplace Injury

b) ☐ Motor Vehicle Accident (MVA) **d)** ☐ Pregnancy **EDC:** ____________

IV. Date of: **First visit:** ____________ **Last visit:** ____________ **Reassessment Date:** ____________

V. Unable to work ☐ **From:** ____________ **To:** ____________

VI. Prognosis for Return to Work: ☐ EXCELLENT ☐ GOOD ☐ GUARDED

VII. Expected return to work: **Date:** ____________

☐ Regular Duties ☐ Temporary Modified Duties (Duration): ____________

☐ Full Time Modified Hours ☐ Modified Hours (Specify): ____________

VIII. Restrictions/Limitations:

☐ Lifting < 3 kgs ☐ Lifting < 10 kgs ☐ Standing: ________ *Hours per Day* ☐ Sitting: ________ *Hours per Day*
☐ Overhead Work ☐ Walking: ____________
☐ Pushing/Pulling: ☐ None ☐ Light ☐ Moderate ☐ Bending/Twisting of: ____________
☐ Lifting Floor to Waist: ____________ ☐ Chemical/Environmental exposure to: ____________
☐ Lifting Waist to Shoulder: ____________ ☐ Cognitive: ☐ Good ☐ Adequate ☐ Poor
☐ Other (**PLEASE ELABORATE IN COMMENTS SECTION**)

Comments: (e.g. Frequency of therapy/treatment, medication side effects, driving, operating equipment, stairs/ladder climbing, cognitive restrictions, other restrictions, etc.). Please add page if necessary.

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IX. Family Physician? ☐ **Specialist?** ☐ Practitioner's Name (Please Print): ____________

Address: ____________

Phone: ____________ **Fax:** ____________

Signature: ____________ **Date:** ____________

Physician/Practitioner's stamp

X. Note: When the employer requests a second written medical opinion, the cost of any such opinion will be borne by the employer.

Instructions: Medical Absence/Accommodation Certificate (MAAC)

The **Medical Absence/Accommodation Certificate (MAAC)** is York University's form to collect the necessary information needed to address an employee's absence from work up to and including LTD application or a request for accommodation. All medical information received will be kept in strict confidence in the employee's medical file at the offices of Health, Safety & Employee Well-Being (HSEWB).

Part A - Academic/Non-Academic Employee Identification and Authorization

Please provide up-to-date employee contact information to facilitate communication with HSEWB. Ensure that the consent for release of information is signed to enable your treating practitioner to provide medical information on this form for the purposes of determining fitness to work, the need for workplace accommodation and/or substantiating absence and eligibility for benefits due to illness or injury.

Part B - Attending Practitioner's Report

This section is to be completed only by the employee's treating practitioner.

The Ontario Medical Association (OMA) outlines in its "**Position in Support of Timely RTW Programs and the role of the Practitioner**", that practitioners should provide **objective** reports on **impairment**, medical restrictions and other supporting advice to Academic/Non-Academic employees. Upon receipt of this information, **YORK UNIVERSITY** will offer, as necessary, a modified or graduated, "Return to Work" program, time limited (normally 4 – 6 weeks) designed to facilitate the timely and safe return of Academic/Non-Academic employees who are recovering from injury or illness.

I. Absence/Accommodation due to: Please indicate if absence and/or accommodation is related to an illness or injury.

II. Nature of Illness/Injury: Please indicate the nature of illness/injury; disclosure of diagnosis is not being requested.

III. Does the current illness or injury involve:

- **a) A communicable disease reportable to Public Health:** information requested to enable implementation of health and safety precautions for the employee and the workplace, as well as assisting in determining accommodation requirements.
- **b) Motor Vehicle Accident (MVA):** information requested to ensure, where applicable, the involvement of third party stakeholders for the absence from work, return to work and accommodation.
- **c) Workplace injury:** requires reporting to the Workplace Safety and Insurance Board (WSIB).
- **d) Pregnancy** and the **estimated date of confinement (EDC):** information requested to ensure EI benefits are considered given the circumstances if required.

IV. Date of field: Please specify first, last visit and reassessment date.

***First visit*:** Date the employee first sought treatment for this medical issue. This information is also required if application for long-term disability (LTD) benefits is expected.
***Last visit*:** Date the employee was last seen by the treating practitioner.
***Reassessment date*:** Date the employee will be reassessed by the treating practitioner.

V. Unable to work field: Provide specific dates regarding the anticipated period of absence.

VI. Prognosis for Return to Work: This information assists in determining what can be expected around ability to attend work and/or planning for return to work. Prognosis is also used to assist in determining if an application for long-term disability benefits is required.

VII. Expected Return to Work: Please provide the employee's expected Return to Work (RTW) date and whether the employee will be returning to regular duties or will require an accommodation of hours or duties.

VIII. Restrictions/Limitations: Please provide information regarding restrictions and limitations to facilitate Return to Work (RTW) planning. Where necessary, please elaborate on restrictions and limitations or other information in the comments section. If *Other* is chosen, please ensure that further detail is provided in the Comments section below. Addendums can be attached if necessary. If clarification is required, additional details may be requested by Health, Safety and Employee Well-Being (HSEWB) to facilitate a safe return to work and development of a Work Accommodation Plan (WAP).

IX. Treating Practitioner: Please identify if the Physician/Practitioner completing the form is a family physician or a specialist, and provide the Physician/Practitioner's name, address, and phone number. Ensure the document is signed and/or stamped.

X. Cost reimbursement: The employee will be reimbursed if the Employer requests a second written medical opinion or clarification, as per Collective Agreement language and at the cost the employee was charged by the treating physician.