

# SICK LEAVE PLAN

PRIVATE PHYSICIAN REPORT TO EMPLOYER (Fax to 250-364-4304)



<b>Employee Name:</b>		<b>Emp #:</b>	
<i>I hereby authorize physicians, hospitals, or other medical providers to release any information or copies thereof acquired in the course of examinations or treatment for the injury/illness identified below as requested by Teck Metals Ltd. Claims and Disability Management. The authorization is only for information relevant to this absence, and I understand that Teck Metals Ltd. will keep such information confidential solely for the purposes of administering the claim.</i>			
<b>Employee Signature:</b>		<b>Date:</b>	
<b>To Be Completed By Private Physician / Medical Practitioner</b>			
What medical restrictions/limitations are there that disable the employee from doing their normal job?			
Has or will a claim be filed with WorkSafeBC?		YES	NO
Date of injury/sickness for this claim:			
Date of first visit for this claim:		Date of latest visit/treatment for this claim:	
Date admitted to hospital:		Date discharged from hospital:	
Is the employee following a treatment plan?		YES	NO
If so, have you been actively supervising this patients' care?		YES	NO
Please check: <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify): _____			
Is the employee in receipt of medications that will impact their ability to perform safety sensitive work?		YES	NO
Specify if patient has been referred to:			
<input type="checkbox"/> Physiotherapist <input type="checkbox"/> Specialist (Type of specialist): _____ Referral date: _____			
<b>Current Medical Status (Please complete one of the following)</b>			
<b>Able to return to work at own occupation with no limitations</b>	YES	NO	Date:
<b>Able to return with restrictions/limitations, please list</b> (i.e., Driving, bending, lifting/pushing/pulling (weight limits?), walking, climbing ladders, standing, sitting, stairs, shift length):			
These limitations are in effect until:			Date:
or until employee is reassessed on:			Date:
<b>Totally Incapacitated – unable to perform any work</b>		Employee will be re-assessed on:	Date:
Target return to work:			Date:
Physician's Signature:		Date:	
Physician's Name (please print):		Address:	