Non – Occupational Injury/Illness Status Report (ISR) – Fire Employees

EMPLOYEE: This form must be completed in full to ensure eligibility for sick leave entitlement.

HEALTH CARE PROVIDER: The City of St. Catharines is requesting that you provide our employee with an assessment to identify appropriate modified work or to confirm eligibility for sick leave entitlement.

Employee Section:

Employee Name: _____ **Employee Number:** _____

Job Title: _____ **Department:** _____

Current Contact Telephone Number: _____ **Alternate Telephone Number:** _____

Date Injury/Illness Commenced: _____

PLEASE RETURN THE COMPLETED FORM:

via Confidential Fax at: **(905) 687-3494**
via E-mail at: fireisr@stcatharines.ca
Hand Delivered to: **Platoon Chief or Administration**

This form is also available on-line at: http://www.stcatharines.ca

The cost of this form is the responsibility of the employee. Employees will be reimbursed in accordance with Corporate Policy.

Health Care Provider Section:

☐ Injury Date of Injury (MM/DD/YY): _____

☐ Illness Commencement of Illness (MM/DD/YY): _____

☐ Surgery Date of Surgery (MM/DD/YY): _____

Prognosis:

_____

Date of this Assessment:	Date First Assessed (for this condition):

Has a referral to another Health Care Professional been made? □ Yes (optional – please specify): _____ □ No

If yes, will you continue to be the patient's primary health care practitioner? □ Yes □ No

Follow-up appointment required? □ Yes (date of next appointment): _____ □ No

….please continue to page 2

Employee Name: _____

Health Care Provider to Complete:

Section A **Please check the box below that reflects your overall assessment of this patient:**

☐ Capable of returning to work with **no restrictions** effective immediately. **Please proceed to SIGN-OFF at bottom of page.**	☐ Capable of returning to work **with restrictions** effective immediately. **Estimated duration:** _____ **Please complete section B below.**	☐ Unable to return to work at this time. ***ADDITIONAL INFORMATION REQUIRED FOR BENEFIT ENTITLEMENT:*** **Estimated Date of Return to Work:** _____ **Please complete Section B below to identify how the injury/illness prevents your patient from returning to work in any capacity.**

Section B

Contagious / Infectious Illness: □ Yes □ No	**Restrictions related to medication use:** □ Yes (list restrictions) □ No	**Restrictions related to driving / operating equipment:** □ Yes (specify) □ No	**Walking:** □ Full abilities □ None □ Other:
Standing: □ Full abilities □ None □ Other:	**Sitting:** □ Full Abilities □ None □ Other:	**Ability to use hands:** □ Full Abilities □ None □ Other:	**Pushing/Pulling:** □ Full Abilities □ None □ Other:
Lifting from floor to waist: □ Full Abilities □ None □ Other:	**Lifting from waist to shoulder:** □ Full Abilities □ None □ Other:	**Work at or above shoulder level:** □ Full Abilities □ None □ Other:	**Stair Climbing:** □ Full Abilities □ None □ Other:
Ladder Climbing: □ Full Abilities □ None □ Other:	**Cognitive:** □ No Deficit □ Mild Deficit □ Moderate Deficit □ Severe Deficit		

If reduced or graduated hours are required, please specify:

SIGN-OFF

(OFFICE STAMP)

Health Care Provider's Name:	
Signature:	
Date:	
Phone Number:	**Fax Number:**