



CREDIT VALLEY
THE CREDIT VALLEY HOSPITAL

SHORT TERM SICK PAY BENEFIT APPLICATION FORM

The Credit Valley Hospital (CVH) requires that all absences of four (4) or more consecutive scheduled workdays be approved with the submission of this form. The information provided by the employee will be used to determine eligibility for Short Term Sick Pay Benefits during absence from work. Please complete and return this form to ACCLAIM Ability Management by fax 905-813-4542 by email to cvh@acclaimability.com, or in person to the CVH Occupational Health & Safety department by your fourth (4th) consecutive scheduled workday of absence. *Failure to submit your application on time may result in disruption to your pay.*

SECTION A: EMPLOYEE INFORMATION

NAME: _____ FIRST DAY ABSENT: ____ / ____ / 20 ____
CVH DEPARTMENT/POSITION: _____ CONTACT PHONE (H): _____

SECTION B: ILLNESS / INJURY INFORMATION

IS THE ILLNESS / INJURY WORK RELATED? YES NO HAVE YOU SEEN A PHYSICIAN? YES NO

DATE PHYSICIAN SEEN: ____ / ____ / 20 ____

NAME OF PHYSICIAN SEEN: _____ PHONE: _____

DESCRIBE YOUR RESTRICTIONS / LIMITATIONS: _____

CAN YOU PERFORM MODIFIED WORK? YES NO ; EXPECTED RETURN TO WORK: ____ / ____ / 20 ____

GENERAL NATURE OF ILLNESS/INJURY: _____

TREATMENT PLAN: _____

EMPLOYEE SIGNATURE: _____ DATE: ____ / ____ / 20 ____

SECTION C: VOLUNTARY CONSENT TO THE RELEASE OF MEDICAL INFORMATION

The Consent below is voluntary; you may choose whether to provide it or not. However, in some cases, a decision not to provide consent may affect or delay eligibility for benefits or the ability to return to regular or modified work. In these cases you will be contacted.

I authorize the physician or specialist involved with my treatment as it relates to my current absence, to provide CVH's Occupational Health & Safety and / or ACCLAIM Ability Management with the information requested on this form. Medical information will remain confidential. Only information regarding restrictions and limitations affecting my ability to return to work will be shared with my Manager, Human Resources, Union and others who may be involved in the accommodation or return to work process. This Consent to the Release of Medical Information is valid until I have returned to regular work.

_____ **Please initial here to indicate your consent if submitting by email.**

EMPLOYEE SIGNATURE: _____ DATE: ____ / ____ / 20 ____

Your ACCLAIM Ability Management and Return to Work Coordinator can be reached through CVH's Occupational Health & Safety Receptionist at ext: 3975 or by email at cvh@acclaimability.com.