CANADIAN PACIFIC RAILWAY

Occupational Health Services

CANADIAN PACIFIC RAILWAY RETURN TO WORK FORM TO BE COMPLETED BY THE TREATING PHYSICIAN

(CSST/WCB/WSIB Cases only)

IMPORTANT INFORMATION:

Dear Physician:

Consistent with CSST/WCB/WSIB legislation, Canadian Pacific Railway (CPR) has developed a Return To Work program for accommodating employees with impairment due to injury or illness. The primary goal of our Return To Work Program is to assist employees with impairment due to medical reasons to return to work and/or remain at work. This program includes modified or alternate duties for employees with restrictions. Many positions occupied by Canadian Pacific Railway employees are critical to safe railway operations and as such, impact on the safety of the public and/or other employees. As such, we need your assistance in completing PART 3 of this form.

PART 1: To Be Completed by Supervisor

NAME OF EMPLOYEE:
EMPLOYEE NUMBER:
POSITION:
TELEPHONE NUMBER:
NAME OF SUPERVISOR:
ADDRESS OF SUPERVISOR:
PHONE NUMBER OF SUPERVISOR:
FAX NUMBER OF SUPERVISOR:

PART 2: Employee Consent – To be completed and signed by employee.

This consent is valid for a period of six months from date of signature.

I, _____, hereby authorize _____ to provide information about my limitations/restrictions affecting my ability to return to work.

_____	_____
Signature of Patient/Employee	Signature of Witness
_____	_____
Date	Date

PART 3: To Be Completed by Physician

Please complete Part 3 of this form and fax ALL pages as well as your invoice to the employee's supervisor above. DO NOT INCLUDE CONFIDENTIAL MEDICAL INFORMATION.

FITNESS FOR WORK INFORMATION

1. Is your patient fit to return to pre-accident/illness duties? ☐ NO ☐ YES Date:_____
2. Is your patient fit to return to modified duties/hours? ☐ NO ☐ YES Date:_____

If yes, please specify:

☐ **Sedentary** Primarily sitting, with occasional walking/standing. Able to occasionally lift up to 10 lbs.

☐ **Light** Can occasionally lift up to 20 lbs, with frequent lifting and/or carrying up to 10 lbs. Can perform work that entails walking and standing.

☐ **Medium** Can occasionally lift up to 50 lbs, with frequent lifting and/or carrying up to 20 lbs. Can perform work that entails walking and standing.

☐ **Heavy** Can occasionally lift up to 100 lbs. Frequent lifting and/or carrying up to 50 lbs.

Limitations/Restrictions are: Temporary ☐ Duration _____ Permanent ☐

Additional Limitations/Restrictions

	NO	**If YES**	**Please specify Limitation/Restriction**
Sitting	☐	☐	_____
Standing	☐	☐	_____
Lifting and Carrying	☐	☐	_____
Repetitive Use of Upper Limbs	☐	☐	_____
Above Shoulder Work	☐	☐	_____
Bending	☐	☐	_____
Working at Heights	☐	☐	_____
Walking on Uneven Ground	☐	☐	_____
Climbing	☐	☐	_____
Graduated Return to Work	☐	☐	_____
Pushing/Pulling	☐	☐	_____
Other	☐	☐	_____

Modified hours, please specify: _____

3. If your patient is unfit for work at this time, when is the next Re-assessment Date? _____

   Estimated Return to Work Date _____

   Prognosis for Return to Work _____

4. Additional Comments: _____
   _____
   _____

_____ _____

SIGNATURE OF TREATING PHYSICIAN DATE

_____

TREATING PHYSICIAN'S NAME (PRINT)

INVOICE

INFORMATION REGARDING PAYMENT OF MEDICAL REPORT

On receipt of the completed report, Canadian Pacific Railway agrees to pay to the treating physician a fee of $75.00. This fee is used as a guide. It is appreciated that in some circumstances a greater fee may be appropriate commensurate with the physician's time and the detail of the information provided. In such circumstances, a fee in accordance with the current provincial guidelines for uninsured services would be appropriate. In the area provided below, please **CLEARLY PRINT** to whom the cheque should be made payable and the address. Send completed medical report and invoice to employees supervisor indicated on the first page:

PLEASE NOTE: IF NOT WRITTEN LEGIBLY, IT WILL NOT BE POSSIBLE TO PROCESS YOUR PAYMENT.

TO BE COMPLETED BY PHYSICIAN:

Name of Patient: _____

NAME AND ADDRESS OF PERSON AND/OR COMPANY TO WHOM CHEQUE SHOULD BE MADE PAYABLE TO:

Name of TREATING PHYSICIAN **IN PRINT**: _____

TREATING PHYSICIAN'S ADDRESS: _____

_____

TELEPHONE: ( ) _____ FAX: ( ) _____

Date Medical was Completed: _____

FOR CANADIAN PACIFIC RAILWAY USE ONLY:

AMOUNT: $ 75.00 Canadian *ACCOUNT: 65802* *INVOICE#* _____

CoCode: 1000 *Order #*: 7005727 *Order: Yes*

SIGNATURE: _____ *EMPLOYEE NUMBER:* 689619

SIGNATURE: _____ *EMPLOYEE NUMBER:* 689619