Royal Canadian Mounted Police / Gendarmerie royale du Canada

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PIB	PPE 808

Attending Physician's Statement

Occupational Health Services

The Attending Physician's Statement (APS) is to be completed for an absence greater than 40 consecutive hours or for a request for a workplace accommodation due to medical reasons and/or a request for determination to access occupational health benefits. This form is to be returned **directly** to Occupational Health Services.

Section A - Member

Cost Centre (A9999)	HRMIS No.	Full Name	Initials	DOB (yyyy-mm-dd)

Unit Address	Division	Work Telephone No. (incl. area code)	Home Telephone No. (incl. area code)

Personal Email Address	Rank

I hereby consent and authorize my health care practitioner to exchange information concerning my health condition to the Occupational Health Services, Royal Canadian Mounted Police, for the purpose of an occupational health review, assessment of my fitness for duty and to support disability case management, return-to-work planning and/or workplace accommodation and/or a request for determination to access occupational health benefits.

The information is collected by the Royal Canadian Mounted Police Occupational Health Services in order to administer the occupational health programs as per the *RCMP Act* and *RCMP Regulations*, 2014. The information will be collected and maintained pursuant to the *Privacy Act*. The information will be held in accordance to the Personal Information Bank PPE 808.

Fitness for Duty recommendation is subject to revision by Occupational Health Services.

Signature	Date (yyyy-mm-dd)

Section B - Attending Physician

The RCMP will honour professional fees not exceeding those suggested by the provincial/territorial association for this type of administrative service.

Primary Diagnosis (or working diagnosis)

Secondary Diagnoses

Is the patient pregnant? ◯ Yes ◯ No	Expected or Actual Date of Delivery (if applicable; yyyy-mm-dd)	
Date of First Visit for this Condition (yyyy-mm-dd)	Date when your patient became unable to work (yyyy-mm-dd)	Date of Next Visit (yyyy-mm-dd)

Describe the patient's condition in terms of symptoms. Include brief history, severity, and frequency.

Attach copies of all relevant test results/investigations and specialist consultation reports. Please note any pending reports or specialist consultations with expected time lines.

Prognosis

Is complete recovery expected? ◯ Yes ◯ No ◯ Unknown at this time	Expected return to work date (yyyy-mm-dd)

At the expected return to work date, do you recommend the patient return to work

◯ With Limitations and Restrictions (please ensure to complete Section C) ◯ Without Limitations and Restrictions

Date expected duration of limitations/restrictions to start (yyyy-mm-dd)	Date expected duration of limitations/restrictions to end (yyyy-mm-dd)

Treatment Plan

Please outline the treatment plan, including list of medication and surgeries. (date/type, etc.)

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If treatment plan includes surgery or hospitalization provide the following:		
Procedure	Date Admitted (yyyy-mm-dd)	Date of Discharge (yyyy-mm-dd)

Section C - Attending Physician - Physical and/or cognitive Limitations and Restrictions Due to a Medical Diagnosis

Physical Limitation or Restriction

Does your patient have any physical limitation or restriction? ◯ Yes ◯ No

- Restriction: A total inability to complete any part of a task or activity, resulting from an injury or illness.
- Limitation: Any constraint in the performance of the full range of a task or activity, resulting from an injury or illness.
- Example: If the patient's limitation or restriction is listed in the "Activity" column, please indicate if it is a "Restriction". If you selected "No", please provide details regarding the limitation that your patient has. (e.g. Lifting: limited to 10 lbs on an occasional basis)
- Limitations: Limitation - Occasional: (0-33% of the workday); Limitation - Frequent: (34-66% of the workday); Limitation - Constant: (67-100% of the workday)

Activity	Restriction	Limitation - Indicate weight, duration or distance	Limitation - Occasional	Limitation - Frequent	Limitation - Constant	Comments
Lifting	◯ Yes ◯ No		☐	☐	☐	
Carrying	◯ Yes ◯ No		☐	☐	☐	
Push/Pull	◯ Yes ◯ No		☐	☐	☐	
Walking	◯ Yes ◯ No		☐	☐	☐	
Running	◯ Yes ◯ No		☐	☐	☐	
Standing	◯ Yes ◯ No		☐	☐	☐	
Sitting	◯ Yes ◯ No		☐	☐	☐	
Other:	◯ Yes ◯ No		☐	☐	☐	
Other:	◯ Yes ◯ No		☐	☐	☐	

Cognitive/Mental Limitation or Restriction

Does your patient have any cognitive/mental limitation or restriction? ◯ Yes ◯ No

- Restriction: A total inability to complete any part of a task or activity, resulting from an injury or illness.
- Limitation: Any constraint in the performance of the full range of a task or activity, resulting from an injury or illness.
- Example: If the patient's limitation or restriction is listed in the "Activity" column, please indicate if it is a "Restriction". If you selected "No", please provide details regarding the limitation that your patient has. (e.g. Comprehension limitation: must receive instructions in writing)

Activity	Restriction	Limitation - Provide Details (if applicable)
Concentration (e.g. attention)	◯ Yes ◯ No	
Memory (e.g. learn new material)	◯ Yes ◯ No	
Analytical Reasoning (e.g. judgement)	◯ Yes ◯ No	
Operating a Vehicle	◯ Yes ◯ No	
Comprehension	◯ Yes ◯ No	
Social Interaction (e.g. mood)	◯ Yes ◯ No	
Ability to Multi-task	◯ Yes ◯ No	
Other:	◯ Yes ◯ No	
Other:	◯ Yes ◯ No	

Comments

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Section D - Attending Physician - Indication of Work Related Injury/Illness

Is the member reporting that their condition is due to a workplace incident/injury? ◯ Yes ◯ No	Date of Accident/Injury (yyyy-mm-dd)
In your opinion, is the medical diagnosis related to the reported work-related incident?	

Attending Physician Information

Name and Address or Stamp of Health Care Practitioner		
License Number	Signature	Date (yyyy-mm-dd)

Section E - Distribution

- Member's Divisional Occupational Health File