OPTrust

OPSEU Pension Trust | Fiducie du régime de retraite du SEFPO

Medical Examination Report

OPSEU Pension Trust 1 Adelaide Street East, Suite 1200, Toronto, Ontario M5C 3A7
Telephone: 416-681-6100 Toll-free: 1-800-637-0024 Fax: 416-681-6175

APPLICANT'S DATA

Employee Last Name | **First Name and Initials** | OPTrust ID Number | WIN Number

Home Address: Number and Street | Apt. No. | Date of Birth (DD/MM/YYYY) D D M M Y Y Y Y

City/Town | Province | Postal Code | Last day of work? (DD/MM/YYYY) D D M M Y Y Y Y

MEMBER'S CONSENT TO RELEASE MEDICAL INFORMATION

I AUTHORIZE any physician, medical practitioner, employer representative, agency providing disability benefits, hospital, clinic, other medical or medically related facility or insurance company, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment or test of me, to give to OPTrust, its medical consultant, or its legal representative, any and all such information.

I AUTHORIZE the medical consultant to use this information to make a recommendation to OPTrust regarding my application for a pension.

I UNDERSTAND the information obtained by use of this authorization will be used by OPTrust in the evaluation of my claim for disability benefits only. Any information obtained will not be released by OPTrust EXCEPT to persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

This authorization or any photographic copy of it shall be valid during the continuation of the claim.

Signature of Applicant | Date Signed (DD/MM/YYYY) D D M M Y Y Y Y

x Sign Here

TO PHYSICIAN: The applicant is applying for disability benefits from the OPSEU Pension Plan. Please complete all sections and stroke out non-applicable areas. In order to help the applicant, provide precise details. It is important to review the accompanying job description and physical demands analysis prior to completing this report.

ATTENTION: This form may be mailed directly to OPTrust or given to the applicant at the physician's discretion.

1. HISTORY

(a) When did the symptoms appear or accident happen? (DD/MM/YYYY) D D M M Y Y Y Y

(b) Date medical condition commenced? (DD/MM/YYYY) D D M M Y Y Y Y

(c) Has applicant ever had same or similar condition? (DD/MM/YYYY)

☐ Yes ☐ No ☐ Unknown If "YES", state when and describe: D D M M Y Y Y Y

(d) Is condition due to injury or sickness arising out of applicant's employment? ☐ Yes ☐ No ☐ Unknown

(e) Describe any pre-existing physical/medical impairment:

(f) Give name, address and telephone number of other treating physicians: | Telephone Number

(g) IMPORTANT: Attach copies of all relevant investigation and consultation reports.

Keep a copy of this form for your records.

2. FINDINGS

Cardiac (if applicable)

(a) Functional capacity ☐ Class 1 (no limitation) ☐ Class 2 (mild limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

(b) Blood pressure (latest visit) Systolic/Diastolic

Visual Impairment (if applicable)

(a) What was vision at latest observation:

	O.D.	O.S.
(i) With glasses		
(ii) Without glasses		

(b) Vision can be restored in whole or in part by:

☐ O.D. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

☐ O.S. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

3. DIAGNOSIS

(a) Diagnosis (including any complications)

Primary

Secondary (if applicable)

(b) Subjective symptoms

(c) Objective findings. Please specify and describe the findings of any special tests including results of current x-rays, EKGs or any other relevant tests.

OTHER FINDINGS (please specify)

4. TREATMENT

(a) Date of first visit: D D M M Y Y Y Y **(b)** Date of latest visit: D D M M Y Y Y Y

(c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (specify):

(d) Is applicant following recommended treatment program? ☐ Yes ☐ No

(e) Please specify drug treatment in progress if applicable.

(f) What treatment, if any, do you recommend?

(g) Has applicant been examined by certified specialist? ☐ Yes ☐ No If "YES", please provide name and address of specialist and dates examined.

(h) Describe therapy and projected duration of treatment program.

(i) Date and description of surgery, (if applicable). D D M M Y Y Y Y

5. PROGRESS

Has applicant: ☐ Recovered ☐ Improved ☐ Not Improved ☐ Retrogressed?

6. PHYSICAL/MENTAL INCAPACITY

(a) Is the applicant's physical/mental incapacity: ☐ PROLONGED – means the impairment must have lasted for a period of a least 12 continuous months.

DEGREES OF RESTRICTION in the activities of daily work can generally be classified as MILD, MODERATE, MARKED or SEVERE

☐ A MILD LIMITATION is one in which the restriction resulting from the mental or physical impairment is such that, in the absence of treatment or aids, the individual is not prevented from, or is only rarely or intermittently restricted by the impairment in the performance of, or where the continuous use of aids (eg. eye glasses, hearing aids, etc.) or medications restores full or nearly full competence in the performance of the activities or duties of his/her position.

☐ A MODERATE LIMITATION is one in which the restriction resulting from the mental or physical impairment is such that aids or medications fail to produce sufficient compensation of the impairment, with the result that the individual experiences great difficulty in the regular duties of his/her position, but is still capable of working with little reliance on other persons in the performance of his/her duties.

☐ A MARKED LIMITATION is one in which aids or medications substantially fail to produce sufficient compensation of the impairment with the result that the individual experiences great limitations on his/her ability to perform the duties of his/her position.

☐ SEVERE – means the impairment **markedly** restricts the person's performance of regular duties. What must be considered is not so much the presence of an ailment or condition, but rather how the condition/impairment **affects** the person's ability and capacity to perform the regular duties of his/her position.

(b) Biomechanical limitations:

(c) Neuropsychological limitations:

Note: Refer to attached physical demands analysis for essential duties of position.

7. EFFECT OF PHYSICAL OR MENTAL INCAPACITY ON ESSENTIAL DUTIES

Please explain the extent to which the applicant's illness or injury affects his or her capacity to:

(a) perform his or her regular duties

(b) perform the duties of a similar position in the same job class

(c) perform his/her duties of a similar position in the same class, with modifications or accommodations?

(d) if applicable, please specify possible physical/medical accommodations

(e) can you suggest a suitable alternative position in the same class given applicant's possible physical mental incapacity?

(f) is applicant a suitable candidate for any other employment?

(g) is applicant a suitable candidate for vocational counselling?

(h) is retraining recommended?

8. PROGNOSIS

(a) Is applicant now unable to perform his/her duties?

	For regular position:	Similar position – same class and grade:
	☐ Yes ☐ No	☐ Yes ☐ No
	☐ With modification	☐ With modification
	☐ Without modification	☐ Without modification
If "NO", when was applicant able to resume work?	D D M M Y Y Y Y	D D M M Y Y Y Y
If "YES", when should applicant be able to resume work?	D D M M Y Y Y Y	D D M M Y Y Y Y

(b) If indefinite, the estimated number of additional weeks/months before applicant's return _____ weeks _____ months

(c) If "YES", or indefinite, is applicant a suitable candidate for some form of trial modified employment? ☐ Yes ☐ No

(d) Is applicant a suitable candidate for trial employment? For regular occupation: ☐ Yes ☐ No Any other occupation: ☐ Yes ☐ No

If "YES", when could trial employment commence: D D M M Y Y Y Y | D D M M Y Y Y Y

If "YES", when should applicant be able to resume work? ☐ Full time ☐ Part-time

If "NO", please explain:

(e) Would vocational counselling and/or retraining be recommended? ☐ Yes ☐ No

REMARKS

Physician's Name (Print)

Certified Specialist? ☐ Yes ☐ No

If "YES", indicate specialty

Address: Number and Street

Suite Number

City/Town

Province

Postal Code

Telephone Number

Signature

x Sign Here

Date Signed (DD/MM/YYYY) D D M M Y Y Y Y