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CANADIAN PACIFIC RAILWAY
MEDICAL REPORT FORM

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GENERAL INFORMATION

Dear Doctor:

The primary goal of our Return To Work Program is to assist employees who are absent from work due to medical reasons to return to work in a timely and safe manner. You should be aware that many positions occupied by CPR employees are critical to safe railway operations and as such, impact on the safety of the public and/or other employees.

Please complete this form and **Fax (Fax #: 403-319-6803)**, along with one copy of the consent form to:

Occupational Health Services
Canadian Pacific Railway
Suite 345, 401 - 9TH Ave. S.W.
Calgary, T2P 4Z4

Medical Reports must be received in Occupational Health Service 5 to 10 days before return to work date.

You will be re-imbursed $35 for legibly completing the form, PLEASE ATTACH YOUR INVOICE. Thank you

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PART A : TO BE COMPLETED BY DEPARTMENT

WCB: ( ) **LTD: ( )** **WIB: ( )** **OTHER: ( )**

NAME OF THE EMPLOYEE: ______________________________

EMPLOYEE NUMBER: ____________________ EMPLOYEE TELEPHONE#:

POSITION:

SUPERVISOR'S NAME: ____________________ MERLIN I.D.:

SUPERVISOR'S PHONE NUMBER: ______________________________

PART B : TO BE COMPLETED BY TREATING PHYSICIAN

1. DATE OF INJURY/ONSET OF ILLNESS:

2. FIRST DAY OF ABSENCE:

3. DIAGNOSIS:

4. TREATMENT: (indicate dates started/ended)

A) Medical: (e.g. referrals, investigations, surgery, physiotherapy etc.)

B) Current Medications: (state dosage, time of administration and expected duration of utilization):

5. RECOMMENDED DATE OF RETURN TO WORK (If applicable):

____

6. Is your patient fit to work without restrictions?

Yes ( ) No ( )

7. If there are restrictions, please specify:

7.1 Anticipated duration of the restrictions:

7.2 Do you plan to reassess your patient? If so, please indicate the date:

8. If your patient must take any form of medication or suffers from any mental condition, which can affect his/her coordination, judgment and alertness, or impact on safe performance in any way, please advise, according to your observation, if the medication has any effect on his/her:

	YES	NO
- Alertness	( )	( )
- Attention	( )	( )

- Orientation ( ) ( )
- Judgment ( ) ( )
- Memory ( ) ( )
- Mood (i.e., manic behavior) ( ) ( )
- Psychomotor functions ( ) ( )

9. To the best of your knowledge, does your patient suffer from any illness which can result in sudden impairment?

YES ( ) NO ( )

If yes, please provide details:

10. In your opinion, is your patient capable of performing duties that are critical to his/her own safety or to safety of others?

YES ( ) NO ( )

11. ADDITIONAL COMMENTS:

12. Do you wish to discuss your patient's condition with the Company's Regional Physician?

YES ( ) NO ( )

Please append any report (from specialists, laboratory, X-Rays, etc...) that you judge pertinent.

____

____

SIGNATURE OF TREATING DOCTOR DATE:

NAME IN PRINT: ______________________________

TREATING DOCTOR'S ADDRESS:

____

____

TREATING DOCTOR'S TELEPHONE NUMBER: (   )

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APPENDIX 1

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OCCUPATIONAL & ENVIRONMENTAL HEALTH
CANADIAN PACIFIC RAILWAY

AUTHORIZATION TO RELEASE
HEALTH/MEDICAL INFORMATION
(Treating physician's copy)

To Whom It May Concern:

I, ______________________________________, hereby authorize Dr.______________________________ to release information concerning my present medical condition to the office of the Chief Medical Officer. CPR. I fully understand that only the restrictions related to my present condition will be transmitted to my employer.

_________________________________ _____________________________

Signature of employee Signature of witness

Date: ____

* This authorization is valid for a period of six months from the date of signature.

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APPENDIX 2

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OCCUPATIONAL & ENVIRONMENTAL HEALTH
CANADIAN PACIFIC RAILWAY

AUTHORIZATION TO RELEASE
HEALTH/MEDICAL INFORMATION
(Rerional physician's copy)

To Whom It May Concern:

I, ______________________________, hereby authorize Dr.________________________
to release information concerning my present medical condition to the office of the Chief Medical Officer. CPR. I fully understand that only the restrictions related to my present condition will be transmitted to my employer.

__________________________ __________________________

Signature of employee Signature of witness

Date: ____________________________________

* This authorization is valid for a period of six months from the date of signature.

INFORMATION REGARDING PAYMENT
FOR RETURN TO WORK

Within 30 days of receipt of the completed report, Canadian Pacific Railway agrees to pay to the treating physician a fee not to exceed $35.00. We are unable to process payment unless this form is completed and returned.

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:

Canadian Pacific Railway
#345 401 9th Avenue SW.
Gulf Canada Square
CALGARY, Alberta T2P 4Z4
ATTENTION: OHS DEPARTMENT

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

INVOICE
TO BE COMPLETED BY PHYSICIAN:

Employee: ______________________________

Employee No.: ______________________________

Position: ______________ Department: ______________

Name and Address of Person and/or Company to whom cheque should be made payable to:

To whom cheque should be made out to:

____

Address: ______________________________

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City: ______________________________

Province: ______________________________

Postal Code: ______________________________

Date Medical was completed: ______________________________

Telephone: ______________________________

Fax: ______________________________