



ATU 1415, INSTRUCTION SHEET

Form #1: ATU 1415 - Physician Assessment Form

Form #2: ATU 1415 – Sick Leave Application

Form #1: Physicians Assessment Form (is required to substantiate your absence exceeding 2 days for medical reason(s))

- To be filled in by your physician, Nurse practitioner or licensed health professional
- Must be submitted to have your absence approved.
- This form must be faxed directly to Occupational Health & Safety Nurse to preserve confidentiality of medical information. (Fax # is on the form).
- An extension to sick leave absence requires an updated PAF or a note from physician being submitted to OH&S Nurse at least 3 days prior to the claim ending.
- All costs associated with completion of medical forms are the responsibility of the employee.

Form #2: Sick Leave Application for payment (is required to get sick leave)

- To be filled in by you, the employee, for each pay period showing daily \$ amount(s) claimed for sick leave pay. (If you are spare claim your daily vacation pay amount, DVP5 \$ amount on your pay summary, maximum 6 days per week).
- For Ottawa, this form is to be submitted to Stephan Gleason or Wayne Binda.
- If you work in Montreal, submit to André Simard.
- This form must be completed for you to be paid any sick leave monies you have accumulated.
- Must be completed for the entire time off as indicated on the Physicians Assessment form (could be multiple pay periods), otherwise sick leave payment will be approved only for the period indicated on the sick leave application.
- Please complete additional forms for all subsequent weeks.
- It is the employee's responsibility to request sick leave payment for the entire period of leave.

Once the medical staff reviews your medical information, you will receive a letter at your home address advising you of the decision on your claim. The letter will include contact information if you have questions or concerns.

Due diligence in ensuring our employees are returning to work fit for risk and safety sensitive positions is our top-most priority.

Note: Sick Leave packages are available in drivers' rooms in Ottawa and Montreal or can be emailed if necessary.



ATU 1415 PHYSICIAN'S ASSESSMENT FORM

WHEN COMPLETED PLEASE SEND TO HEALTH & SAFETY NURSE CONFIDENTIAL FAX 1-800-372-3026

Employee Information

to be completed by the Employee

Employee Surname, First Name, Initial	Employee #	Employee's Home Telephone #
Job Title	Work Location	Supervisor's Name & Telephone #
Is this an illness? <input type="checkbox"/> Injury? <input type="checkbox"/> Did this illness/injury occur: on the job <input type="checkbox"/> off the job <input type="checkbox"/>		
Date Absence Started		

Authorization to Release Information

to be completed by the Employee

I authorize the Physician who has signed below to release to Greyhound Occupational Medical Department if requested, medical information that relates to establishing my fitness for work and/or level of disability in regards to this specific illness/injury. Medical information received by the Occupational Medical Department will be kept in strict confidence in my medical file.

X

Employee Signature	Witness	Date
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Physician's Section

to be completed by the Employee's Physician

Date of First Visit _____ Date of Assessment _____ Date to be Reassessed _____

- Describe the limitations based on the illness/impairment: _____
- Describe current treatment (medications, psychotherapy, referral, physio, etc.): _____
- Fit to return to work, **at regular duties**, as of: _____
 - Fit to return to **modified work** with above limitations as of: _____
 - Unfit** for any work. **Estimated return to modified or regular duties:** _____

Comments: _____

Physician's Name (print)	Phone Number
Area of Practice/Specialty	Date
Address	Postal Code
Signature	

This contains confidential medical information once completed.

Please forward to Occupational Health for review by the Occupational Medical Consultant.

If you have any questions or concerns regarding this form, please call the Occupational Health & Safety Nurse Department @ 403-218-1103



ATU 1415 SICK LEAVE APPLICATION

Return a copy to OH&S Nurse via fax (1-800-372-3026) or email (mary-dee.peppinck@greyhound.ca)

Employee Name:		Employee #:	
Address:		City:	Province:
			Postal Code:
Occupation:		Rate of Pay:	Job # as shown on bid:
Sick Leave Duration:	From:	To:	Date Hospitalized:

Please complete: Driver Regular (Complete Section 2) **Pay period:** _____
 Driver Spareboard Hourly (Complete Section 3)

Note: On page 4 include all additional weeks, as per Physicians Assessment Form. Print page 4 for additional weeks.

WEEK 1

SECTION 2

SECTION 3

Dates	Week Days	Trip #s	Total Miles	Rate/M	Value	GCX	Spread	Other	Amount Due	Hours
	Sun									
	Mon									
	Tue									
	Wed									
	Thur									
	Fri									
	Sat									

TOTAL WEEK 1

TOTAL AMOUNT DUE _____

WEEK 2

SECTION 2

SECTION 3

Dates	Week Days	Trip #s	Total Miles	Rate/M	Value	GCX	Spread	Other	Amount Due	Hours
	Sun									
	Mon									
	Tue									
	Wed									
	Thur									
	Fri									
	Sat									

TOTAL WEEK 2

TOTAL AMOUNT DUE _____

Manager's Name: _____

Employee's Name: _____ Employee's Signature: _____ Date: _____

Incomplete forms will be returned for completion prior to processing.

All cost associated with completion of medical forms are the responsibility of the employee.

Deadline to be received by OH&S Nurse: Monday 12:00 (noon) MST



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Return a copy to OH&S Nurse via fax (1-800-372-3026) or email (mary-dee.peppinck@greyhound.ca)

Employee Name:			Employee #:	
Address:		City:	Province:	Postal Code:
Occupation:	Rate of Pay:	Job # as shown on bid:		
Sick Leave Duration:	From:	To:	Date Hospitalized:	

Please complete: Driver Regular (Complete Section 2) **Pay period:** _____
 Driver Spareboard Hourly (Complete Section 3)

Note: Include all additional weeks below, as per Physicians Assessment Form. Print this page for additional weeks.

WEEK _____

SECTION 2

SECTION 3

Dates	Week Days
	Sun
	Mon
	Tue
	Wed
	Thur
	Fri
	Sat

Trip #s	Total Miles	Rate/M	Value	GCX	Spread	Other	Amount Due

Hours

TOTAL WEEK _____

TOTAL AMOUNT DUE _____

WEEK _____

SECTION 2

SECTION 3

Dates	Week Days
	Sun
	Mon
	Tue
	Wed
	Thur
	Fri
	Sat

Trip #s	Total Miles	Rate/M	Value	GCX	Spread	Other	Amount Due

Hours

TOTAL WEEK _____

TOTAL AMOUNT DUE _____

Manager's Name: _____

Employee's Name: _____ Employee's Signature: _____ Date: _____

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