Supplemental Medical Form for Participants of Ontario Works

I _____ DOB:_____ provide consent for my doctor to complete this form, I understand that this medical form is optional and is intended to support my participation in the Ontario Works Employment Program.

Date:_____ Participant Signature: _____

Case Manager Name: _____

The above named person has indicated they have medical limitations. They have asked that their requirement to participate in the Ontario Works employment program be waived because of their medical restrictions. *In order to best support your patient*, your medical assessment of his/her abilities will help all parties to negotiate a suitable return to employment and/or a related activities plan.

This form is supplemental/optional and cannot be billed to OHIP or Ontario Works Social Services. It is provided in addition to the attached Limitations to Participation form which is a provincial form and billable to OHIP. We request your co-operation to provide the information outlined below in order that we may best support your patient with their current medical limitations or restrictions.

1. In completing this medical, do you feel your patient is able to:
   a. Return to his/her previous work or occupation? ☐ Yes ☐ No
   b. Return to any other type of work or occupation? ☐ Yes ☐ No

If yes, approximately date of return _____ Are there limitations to the number of hours they can work (i.e. full or part time hours)_____

If no, please check any of the following options that your patient is able to participate in:

School ☐ Workshops ☐ Volunteer Placements ☐ Training Programs ☐ Other ☐

Expected date of availability:

_____

Full or part-time (hours/day) _____

2. In your opinion, are there any specific factors or conditions of a medical nature that might adversely affect training, employment or academic participation and progress?

_____

3. If the patient's condition(s) interferes with their ability to maintain employment, would you support this person in completing an application for Ontario Disability Support Program (ODSP)?
   If yes, is there enough medical evidence on file at this time to begin an application?

Yes No Not enough information

_____

This form was completed by an Approved Health Professional as follows:

Name (print):_____ Professional Stamp:

Signature: _____

Profession/Occupation: _____