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 Dept 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 Occupational Health Dept no earlier than 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)
- This form is to be submitted to your manager or Occupational Health Dept.
- 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, otherwise sick leave payment will be approved only for the period indicated or the sick leave application (could be multiple pay periods).
- Please complete an 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 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 OCCUPATIONAL HEALTH CONFIDENTIAL FAX 1-800-372-3026

Employee Information — to be completed by the Employee

Employee Surname, First Name, Initial | Employee # | Employee's phone # | Employee's email address

Job Title | Work Location | Supervisor's Name & Telephone #

Is this an illness? ☐ Injury? ☐ Did this illness/injury occur: on the job ☐ off the job ☐

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 Health 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 Health Department will be kept in strict confidence in my medical file.

X _____ _____ _____

Employee Signature | Witness | Date

Physician's Section — to be completed by the Employee's Physician

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

1. Describe the limitations based on the illness/impairment: _____

2. Describe current treatment (medications, psychotherapy, referral, physio, etc.): _____

3. 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 the completion of this form, please call 289-288-4359 Ext 1148

ATU 1415 SICK LEAVE APPLICATION

Return a copy to OH&S via fax (1-800-372-3026) or email (sarah.miyanji@greyhound.ca)

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

Please complete: ☐ Driver Regular (Complete Section 2) ☐ Non-Union **Pay period:** _____

☐ Driver Spareboard ☐ Hourly (Complete Section 3)

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

WEEK 1

Dates	Week Days
	Sun
	Mon
	Tue
	Wed
	Thur
	Fri
	Sat

TOTAL WEEK 1

SECTION 2

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

TOTAL AMOUNT DUE

SECTION 3

Hours

WEEK 2

Dates	Week Days
	Sun
	Mon
	Tue
	Wed
	Thur
	Fri
	Sat

TOTAL WEEK 2

SECTION 2

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

TOTAL AMOUNT DUE

SECTION 3

Hours

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: Monday 12:00 (noon) EST

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Return a copy to OH&S via fax (1-800-372-3026) or email (sarah.miyanji@greyhound.ca)

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

Please complete: ☐ Driver Regular (Complete Section 2) ☐ Non-Union **Pay period:** _____

☐ Driver Spareboard ☐ Hourly (Complete Section 3)

WEEK _____

Dates	Week Days
	Sun
	Mon
	Tue
	Wed
	Thur
	Fri
	Sat

TOTAL WEEK____

SECTION 2

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

TOTAL AMOUNT DUE

SECTION 3

Hours

WEEK _____

Dates	Week Days
	Sun
	Mon
	Tue
	Wed
	Thur
	Fri
	Sat

TOTAL WEEK____

SECTION 2

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

TOTAL AMOUNT DUE

SECTION 3

Hours

Manager's Name: _____

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

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