CANADIAN PACIFIC

Dear Treating Physician,

Canadian Pacific Railway (CP) has a Return To Work program to assist injured workers back to pre-injury duties as soon as they are medically able. This program includes modified or alternate duties for employees with work limitations and/or restrictions.

CP employees can occupy one of the following safety categories: Safety Critical, Safety Sensitive and Non-Safety Sensitive. **Your patient is in a Safety Critical Position**.

**Safety Critical Positions** are mandated by Transport Canada and have a direct role in safe railway operations where impaired performance due to a medical condition could result in a significant incident affecting the health and safety of employees, the public, property or the environment. e.g. **Locomotive Engineers, Conductors and Rail Traffic Controllers**.

You are responsible under the Railway Safety Act to notify the Railway Company Chief Medical Officer if an employee has a medical condition that could be a threat to safe railway operations. These conditions are listed in Part 1 of the attached Functional Abilities Form.

Please complete Part 4 of the form. In addition if your patient is presenting with any of the listed medical conditions you are required to also complete Part 5 of the form

The attached Job Demands Analysis may assist you in understanding the job requirements.

**Please fax the completed form and invoice to OHS at 1 403 319 6803.**

Thank you for your cooperation and assistance with our program.

# FITNESS TO WORK CONSIDERATIONS FOR SAFETY CRITICAL POSITIONS

(Taken from the CMA Driver's Guide 7th Edition)

The physical and mental capabilities that must be reviewed when considering fitness for duty for any safety critical position include, but are not limited to:

1. Cognition: must have normal function for:

    - Alertness
    - Judgment
    - Concentration
    - Comprehension of *concurrent* written, verbal and signal-based communication
    - awareness of the environment and other members of the work crew, and
    - vigilance for prolonged periods.

2. Special senses: visual, including color perception, and hearing must meet government legislated standards

3. Ability to tolerate and function in a stressful work environment; which includes a highly variable work shift.

4. Must not be subject to sudden impairment of physical or mental capabilities.

The following capabilities **must also be assessed**, depending on the specific job function:

**LOCOMOTIVE ENGINEER**

- Must be able to walk in variable weather conditions and on uneven terrain.
- Is required on a rare basis (between 1-5% of shift) to climb ladder to get on/off unit
- May be required very rarely to lift over 50lbs from floor to waist level (lifting the knuckle)

**CONDUCTOR (BRAKEPERSON / YARDPERSON / TRAINMAN)**

- Must be able to walk in variable weather conditions and on uneven terrain.
- Is required on an occasional basis (between 6-33% of shift) to climb ladder to get on/off unit and railcars. Brakeperson/Yardperson may be required to do this more frequently.
- May be required very rarely to lift over 50lbs from floor to waist level (lifting the knuckle)
- Good strength and endurance is required in the arms, shoulders and upper back.
  e.g. Performing track switching duties requires:
  · 17-19 kgs (37 to 41 lbs) of force to lift switch lever up
  · 18-27 kgs (40 to 60 lbs) of force to pull switch over
  · 17-19 kgs (37 to 41 lbs) of force to lock switch lever back in place
- A good sense of balance is required as these tasks are performed outdoors where terrain may be uneven and slippery, wet, icy or snow covered.

**RAILWAY TRAFFIC CONTROLLER (RTC)**

- Must be able to sit for prolonged periods. Limited physical demands.
- Must have the ability to use a keyboard to enter instructions.
- Must be able to concentrate for prolonged periods while viewing a computer screen and listening and/or reacting to communications simultaneously.

CANADIAN PACIFIC

# FUNCTIONAL ABILITIES FORM
# SAFETY CRITICAL POSITIONS

**PART 1 – INFORMATION FOR THE TREATING PHYSICIAN** **TO BE READ BY TREATING PHYSICIAN**

**Your patient occupies a Safety Critical Position** (Locomotive Engineer, Conductor or Rail Traffic Controller) and **operates or controls the movement of trains.** Impaired performance due to a medical condition could result in a significant incident affecting the health and safety of employees, the public, property or the environment. **As a physician assessing persons occupying these positions you are responsible under the Railway Safety Act to notify the Railway Company's Chief Medical Officer if an employee has a medical condition that could be a threat to safe railway operations.**

Canadian Pacific Railway (CP) appreciates your time in completing this form and will pay you on receipt of the attached invoice. Capabilities that must be reviewed when assessing medical fitness for railway employees in Safety Critical Positions are provided with this form.

**PLEASE FOLLOW THESE STEPS:**

1. **Complete Part 4** – Functional Abilities.
2. If your patient is presenting to you as being off work for this illness or injury due to any of the following medical condition(s) (included in the Canadian Railway Medical Guidelines) then also please **complete Part 5** of this form.
   - Significant Hearing or Vision Deficits
   - Mental Disorder
   - Substance Use Disorder (abuse or dependence)
   - Severe Sleep Apnea
   - Epileptic Seizure
   - Cardiovascular Disorder
   - Diabetes
   - Opioid Pain Medication Use

   - OR, any other medical condition which may pose a threat to safe railway operations,
   - OR, you indicate that your patient is **totally unfit** for any work including non safety sensitive sedentary type office duties.
3. **Fax the completed form to the CP Occupational Health Services (OHS) at (403) 319-6803.**

| **PART 2 – EMPLOYEE INFORMATION** | **TO BE COMPLETED BY THE SUPERVISOR** |
|---|---|
| NAME OF EMPLOYEE: | EMPLOYEE NUMBER: |
| POSITION/JOB NAME: | TELEPHONE #: ( ) |
| THIS INJURY/ILLNESS IS COVERED UNDER: ☐ WCB/WSIB/CSST ☐ WIB ☐ STD | |
| DATE OF INJURY/ILLNESS: | MARVIN INCIDENT #: |
| NAME OF SUPERVISOR: | |
| PHONE # OF SUPERVISOR: ( ) | **FAX # : (403) 319 – 6803** |

**PART 3 – EMPLOYEE CONSENT** **TO BE COMPLETED BY THE EMPLOYEE**

I authorize the healthcare professional who has signed this form to release to CP, i.e. my supervisor, Occupational Health Services and, where applicable, the WCB Specialist, any functional limitations and/or restrictions information that is relevant to my return to work. I also authorize my health care professional to release to and discuss information concerning my present medical condition, solely, with the office of the Chief Medical Officer, OHS, CP. Furthermore, I authorize CP to release Parts 1 through 4 of this form to the appropriate union representative for the purposes of return to work planning. I also authorize OHS, CP, to release all or a portion of the medical information that is relevant to the adjudication of any benefit claim related to my present medical condition to CP's WCB Specialist and the applicable Workers' Compensation Board (WCB) and/or Benefit Carrier. Any use and disclosure of my medical information will be in accordance with legal requirements and CP Policy 1804, Privacy of Information. This consent is valid for a period of six (6) months from the date signed below. Any medical information received by OHS will be kept in my confidential medical file.

| Employee Signature | Witness Signature | Date (dd/mm/yy) |
|---|---|---|

**PART 4 – FUNCTIONAL ABILITIES** **TO BE COMPLETED BY THE TREATING PHYSICIAN**
**(Please ensure NO confidential medical information is included in this part of the form)**

Patient Name: _____ Date of exam on which this report is based: _____ (dd/mm/yy)

Current Pre injury/Illness SCP: ☐ Locomotive Engineer ☐ Conductor ☐ Rail Traffic Controller

☐ **FIT for the USUAL DUTIES** of this position (as described on FTW Considerations for Safety Critical Positions)
☐ Immediately ☐ As of:_____ (dd/mm/yy)

☐ **FIT for MODIFIED / ALTERNATE DUTIES:**
☐ Immediately ☐ As of:_____ (dd/mm/yy) Duration of modified/alternate duties: _____ (week(s)/day(s))

**IF FIT FOR MODIFIED/ALTERNATE DUTIES PLEASE COMPLETE EACH SET OF CHOICES BELOW:**

**WALKING (select all that apply)**
☐ No limitations
☐ Level surfaces only, no uneven ground
☐ No prolonged periods > 30 minutes
☐ Not more than 100 meters
☐ Unable to walk without assistance (cane, crutches)

**CLIMBING AND BALANCE (select all that apply)**
☐ No limitations
☐ No stairs or vertical ladders
☐ Stairs only, no vertical ladders
☐ No working at heights

**STRENGTH (lifting, carrying, pushing, pulling)**
☐ No limitations
☐ Heavy Over 50 lbs
☐ Medium Up to 20 lbs regularly – 50 lbs occasionally
☐ Light Up to 10 lbs regularly – 20 lbs occasionally
☐ Sedentary Up to 10 lbs occasionally.

**POSTURES (select all that apply)**
☐ No limitations
☐ Must be able to change from sitting to standing at own discretion
☐ No sitting duration > 30 minutes
☐ No standing duration > 30 minutes

**UPPER LIMB (select all that apply)**
☐ No limitations
☐ No above shoulder reaching: ☐ Left ☐ Right
☐ No firm gripping or twisting: ☐ Left ☐ Right
☐ No writing or keyboard use: ☐ Left ☐ Right

**OPERATING MOVING EQUIPMENT (select one)**
☐ Can operate moving equipment
☐ Should NOT operate moving equipment

**DRIVING COMPANY VEHICLES (select one)**
☐ Can drive Company vehicles (as per license)
☐ No driving of Company vehicles

**SAFETY CONCERNS (select one)**
☐ Can perform duties requiring cognition, alertness, concentration, attention, judgment, and memory.

☐ Unable to perform duties requiring cognition, alertness, concentration, attention, judgment, and memory. **(Employee may be placed in a Non Safety Sensitive Position)**

**WORK DAY DURATION (select one)**
☐ Able to work full shift
☐ Graduated Work Schedule: ___hrs/day for___week(s)

**PROGNOSIS:**
Complete Recovery expected: ☐ YES ☐ NO Estimated duration of restrictions:_____week(s) ☐ Over 3 mths
Date of next appointment:_____(dd/mm/yy)

☐ ****Totally UNFIT for any work.** Date of reassessment: _____ (dd/mm/yy) Date of expected RTW:_____ (dd/mm/yy)

****FOR WCB/WSIB/CSST CASES**: If you are indicating that your patient is "Totally UNFIT for any work" **(including non-safety sensitive, sedentary office-type duties)**, you MUST also complete the Part 5 – Medical Report and provide objective medical evidence that supports Temporary Total Disability. **In the absence of this information CP may offer temporary accommodation in non safety sensitive sedentary office type duties in accordance with WCB direction.**

**TREATING PHYSICIAN (please print)**

Name (Print):_____ ☐ Family Physician ☐ Specialist (Specify):_____

Signature:_____ Date: _____(dd/mm/yy)

**PART 5 – MEDICAL REPORT** **TO BE COMPLETED BY TREATING PHYSICIAN AS REQUIRED**

**COMPLETE IF YOUR PATIENT IS PRESENTING TO YOU AS BEING OFF WORK FOR THIS INJURY OR ILLNESS DUE TO ANY OF THE FOLLOWING MEDICAL CONDITION(S):**

- Significant Hearing or Vision Deficits
- Mental Disorder
- Substance Use Disorder (abuse or dependence)
- Severe Sleep Apnea
- Epileptic Seizure
- Cardiovascular Disorder
- Diabetes
- Opioid Pain Medication Use

OR

- Any other medical condition which may pose a threat to safe railway operations.

Patient Name: _____ DOB (dd/mm/yy): _____

**DIAGNOSIS (please be specific):**

A) _____ B) _____

C) _____ D) _____

**TREATMENT –** Completed and Current: (indicate dates)

Surgery _____ Date (dd/mm/yy) _____
Hospitalization _____ Date(dd/mm/yy) _____
Rehabilitation Program _____ Date(dd/mm/yy) _____
Referrals _____ Date(dd/mm/yy) _____
Investigations _____ Date(dd/mm/yy) _____
Other _____ Date (dd/mm/yy) _____

**CURRENT MEDICATIONS:** (name, dosage, and expected duration of use)

Name : _____ Dosage: _____ Duration: _____
Name : _____ Dosage: _____ Duration: _____
Name : _____ Dosage: _____ Duration: _____
Other(s): _____

**EFFECTS ON COGNITION:** please provide your opinion on any adverse affects due to medication(s) AND/OR medical condition(s) as related to:

| | NO | YES | | NO | YES |
|---|---|---|---|---|---|
| Alertness | ☐ | ☐ | Memory | ☐ | ☐ |
| Attention | ☐ | ☐ | Mood | ☐ | ☐ |
| Orientation | ☐ | ☐ | Psychomotor functions | ☐ | ☐ |
| Judgment | ☐ | ☐ | | | |

In your opinion, does your patient suffer from any medical condition that can result in sudden impairment?

☐ NO ☐ YES, please explain: _____

In your opinion, is your patient capable of performing the duties of a Safety Critical Position?

☐ YES ☐ NO, please explain: _____

Do you wish to discuss your patient's condition with the Company's Occupational Health Nurse?

☐ NO ☐ YES, please specify the issue: _____

**Please append copies of relevant reports from specialists, laboratory, physiotherapy, x-rays, etc.**

**Treating Physician Name (please print)**

Name (Print): _____ ☐ Family Physician ☐ Specialist (Specify): _____

Signature _____ Date: _____
(dd/mm/yy)

**PART 6 – INVOICE (SCP FAF)**

On receipt of the completed report, Canadian Pacific Railway agrees to pay to the treating physician a fee of either $75 for completion of Part 4 only and a fee of $100 for completion of Part 4 and Part 5. This fee is used as a guide. It is appreciated that in some circumstances a greater fee may be appropriate commensurate with the physician's time and the detail of the information provided. In such circumstances, a fee in accordance with the current provincial guidelines for uninsured services would be appropriate. No additional invoice is necessary. Please provide in the space below the person to whom the cheque should be made payable, and the address.

**PLEASE WRITE LEGIBLY TO ASSIST US IN PROCESSING YOUR PAYMENT**

**TO BE COMPLETED FOR PAYMENT**:

Name of Patient:_____

Date form completed:_____ (dd/mm/yy)

Payment made payable to:_____

TREATING PHYSICIAN NAME (**PRINT)**:_____

TREATING PHYSICIAN ADDRESS:_____

_____

_____

_____

_____

_____

TELEPHONE: (  ) _____ FAX: (  ) _____

**FOR CANADIAN PACIFIC RAILWAY USE ONLY**

AMOUNT: ☐ $75 CANADIAN ACCOUNT:65802 INVOICE #:_____

☐ $100 CANADIAN

COCODE: 1000 ORDER # 7005727 ORDER: YES

**I HAVE READ AND APPROVE ACCORDING TO POLICY 6137**

SIGNATURE:_____ EMPLOYEE # 964936

**Fax the completed form to CP Occupational Health Services (OHS) at (403) 319-6803**

CANADIAN PACIFIC

# FUNCTIONAL ABILITIES FORM
# SAFETY CRITICAL POSITIONS

**PART 1 – INFORMATION FOR THE TREATING PHYSICIAN** **TO BE READ BY TREATING PHYSICIAN**

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Canadian Pacific Railway (CP) appreciates your time in completing this form and will pay you on receipt of the attached invoice. Capabilities that must be reviewed when assessing medical fitness for railway employees in Safety Critical Positions are provided with this form.

**PLEASE FOLLOW THESE STEPS:**

1. **Complete Part 4** – Functional Abilities.
2. If your patient is presenting to you as being off work for this illness or injury due to any of the following medical condition(s) (included in the Canadian Railway Medical Guidelines) then also please **complete Part 5** of this form.
   - Significant Hearing or Vision Deficits
   - Mental Disorder
   - Substance Use Disorder (abuse or dependence)
   - Severe Sleep Apnea
   - Epileptic Seizure
   - Cardiovascular Disorder
   - Diabetes
   - Opioid Pain Medication Use

   • OR, any other medical condition which may pose a threat to safe railway operations,
   • OR, you indicate that your patient is **totally unfit** for any work including non safety sensitive sedentary type office duties.
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| **PART 2 – EMPLOYEE INFORMATION** | **TO BE COMPLETED BY THE SUPERVISOR** |
|---|---|
| NAME OF EMPLOYEE: | EMPLOYEE NUMBER: |
| POSITION/JOB NAME: | TELEPHONE #: ( ) |
| THIS INJURY/ILLNESS IS COVERED UNDER: ☐ WCB/WSIB/CSST ☐ WIB ☐ STD | |
| DATE OF INJURY/ILLNESS: | MARVIN INCIDENT #: |
| NAME OF SUPERVISOR: | |
| PHONE # OF SUPERVISOR: ( ) | **FAX TO : (403) 319 – 6803** |

**PART 3 – EMPLOYEE CONSENT** **TO BE COMPLETED BY THE EMPLOYEE**

I authorize the healthcare professional who has signed this form to release to CP, i.e. my supervisor, Occupational Health Services and, where applicable, the WCB Specialist, any functional limitations and/or restrictions information that is relevant to my return to work. I also authorize my health care professional to release to and discuss information concerning my present medical condition, solely, with the office of the Chief Medical Officer, OHS, CP. Furthermore, I authorize CP to release Parts 1 through 4 of this form to the appropriate union representative for the purposes of return to work planning. I also authorize OHS, CP, to release all or a portion of the medical information that is relevant to the adjudication of any benefit claim related to my present medical condition to CP's WCB Specialist and the applicable Workers' Compensation Board (WCB) and/or Benefit Carrier. Any use and disclosure of my medical information will be in accordance with legal requirements and CP Policy 1804, Privacy of Information. This consent is valid for a period of six (6) months from the date signed below. Any medical information received by OHS will be kept in my confidential medical file.

| Employee Signature | Witness Signature | Date (dd/mm/yy) |
|---|---|---|

**PART 4 – FUNCTIONAL ABILITIES** **TO BE COMPLETED BY THE TREATING PHYSICIAN**
**(Please ensure NO confidential medical information is included in this part of the form)**

Patient Name: _____

Date of exam on which this report is based: _____ (dd/mm/yy)

Current Pre injury/Illness SCP: ☐ Locomotive Engineer ☐ Conductor ☐ Rail Traffic Controller

☐ **FIT for the USUAL DUTIES** of this position (as described on FTW Considerations for Safety Critical Positions)
☐ Immediately ☐ As of:_____ (dd/mm/yy)

☐ **FIT for MODIFIED / ALTERNATE DUTIES:**
☐ Immediately ☐ As of:_____ (dd/mm/yy) Duration of modified/alternate duties: _____ (week(s)/day(s))

**IF FIT FOR MODIFIED/ALTERNATE DUTIES PLEASE COMPLETE EACH SET OF CHOICES BELOW:**

**WALKING (select all that apply)**
☐ No limitations
☐ Level surfaces only, no uneven ground
☐ No prolonged periods > 30 minutes
☐ Not more than 100 meters
☐ Unable to walk without assistance (cane, crutches)

**CLIMBING AND BALANCE (select all that apply)**
☐ No limitations
☐ No stairs or vertical ladders
☐ Stairs only, no vertical ladders
☐ No working at heights

**STRENGTH (lifting, carrying, pushing, pulling)**
☐ No limitations
☐ Heavy Over 50 lbs
☐ Medium Up to 20 lbs regularly – 50 lbs occasionally
☐ Light Up to 10 lbs regularly – 20 lbs occasionally
☐ Sedentary Up to 10 lbs occasionally.

**POSTURES (select all that apply)**
☐ No limitations
☐ Must be able to change from sitting to standing at own discretion
☐ No sitting duration > 30 minutes
☐ No standing duration > 30 minutes

**UPPER LIMB (select all that apply)**
☐ No limitations
☐ No above shoulder reaching: ☐ Left ☐ Right
☐ No firm gripping or twisting: ☐ Left ☐ Right
☐ No writing or keyboard use: ☐ Left ☐ Right

**OPERATING MOVING EQUIPMENT (select one)**
☐ Can operate moving equipment
☐ Should NOT operate moving equipment

**DRIVING COMPANY VEHICLES (select one)**
☐ Can drive Company vehicles (as per license)
☐ No driving of Company vehicles

**SAFETY CONCERNS (select one)**
☐ Can perform duties requiring cognition, alertness, concentration, attention, judgment, and memory.

☐ Unable to perform duties requiring cognition, alertness, concentration, attention, judgment, and memory. **(Employee may be placed in a Non Safety Sensitive Position)**

**WORK DAY DURATION (select one)**
☐ Able to work full shift
☐ Graduated Work Schedule: ___hrs/day for___week(s)

**PROGNOSIS:**

Complete Recovery expected: ☐ YES ☐ NO Estimated duration of restrictions:_____week(s) ☐ Over 3 mths

Date of next appointment:_____(dd/mm/yy)

☐ ****Totally UNFIT for any work.** Date of reassessment: _____ (dd/mm/yy) Date of expected RTW:_____ (dd/mm/yy)

****FOR WCB/WSIB/CSST CASES**: If you are indicating that your patient is "Totally UNFIT for any work" **(including non-safety sensitive, sedentary office-type duties)**, you MUST also complete the Part 5 – Medical Report and provide objective medical evidence that supports Temporary Total Disability. **In the absence of this information CP may offer temporary accommodation in non safety sensitive sedentary office type duties in accordance with WCB direction.**

**TREATING PHYSICIAN (please print)**

Name (Print):_____ ☐ Family Physician ☐ Specialist (Specify):_____

Signature:_____ Date: _____(dd/mm/yy)

**PART 5 – MEDICAL REPORT** **TO BE COMPLETED BY TREATING PHYSICIAN AS REQUIRED**

**COMPLETE IF YOUR PATIENT IS PRESENTING TO YOU AS BEING OFF WORK FOR THIS INJURY OR ILLNESS DUE TO ANY OF THE FOLLOWING MEDICAL CONDITION(S):**

- Significant Hearing or Vision Deficits
- Mental Disorder
- Substance Use Disorder (abuse or dependence)
- Severe Sleep Apnea
- Epileptic Seizure
- Cardiovascular Disorder
- Diabetes
- Opioid Pain Medication Use

OR

- Any other medical condition which may pose a threat to safe railway operations.

Patient Name: _____ DOB (dd/mm/yy): _____

**DIAGNOSIS (please be specific):**

A) _____ B) _____

C) _____ D) _____

**TREATMENT –** Completed and Current: (indicate dates)

Surgery _____ Date (dd/mm/yy) _____
Hospitalization _____ Date(dd/mm/yy) _____
Rehabilitation Program _____ Date(dd/mm/yy) _____
Referrals _____ Date(dd/mm/yy) _____
Investigations _____ Date(dd/mm/yy) _____
Other _____ Date (dd/mm/yy) _____

**CURRENT MEDICATIONS:** (name, dosage, and expected duration of use)

Name : _____ Dosage: _____ Duration: _____
Name : _____ Dosage: _____ Duration: _____
Name : _____ Dosage: _____ Duration: _____
Other(s): _____

**EFFECTS ON COGNITION:** please provide your opinion on any adverse affects due to medication(s) AND/OR medical condition(s) as related to:

| | NO | YES | | NO | YES |
|---|---|---|---|---|---|
| Alertness | ☐ | ☐ | Memory | ☐ | ☐ |
| Attention | ☐ | ☐ | Mood | ☐ | ☐ |
| Orientation | ☐ | ☐ | Psychomotor functions | ☐ | ☐ |
| Judgment | ☐ | ☐ | | | |

In your opinion, does your patient suffer from any medical condition that can result in sudden impairment?

☐ NO ☐ YES, please explain: _____

In your opinion, is your patient capable of performing the duties of a Safety Critical Position?

☐ YES ☐ NO, please explain: _____

Do you wish to discuss your patient's condition with the Company's Occupational Health Nurse?

☐ NO ☐ YES, please specify the issue: _____

**Please append copies of relevant reports from specialists, laboratory, physiotherapy, x-rays, etc.**

**Treating Physician Name (please print)**

Name (Print): _____ ☐ Family Physician ☐ Specialist (Specify): _____

Signature _____ Date: _____
(dd/mm/yy)

**PART 6 – INVOICE (SCP FAF)**

On receipt of the completed report, Canadian Pacific Railway agrees to pay to the treating physician a fee of either $75 for completion of Part 4 only and a fee of $100 for completion of Part 4 and Part 5. This fee is used as a guide. It is appreciated that in some circumstances a greater fee may be appropriate commensurate with the physician's time and the detail of the information provided. In such circumstances, a fee in accordance with the current provincial guidelines for uninsured services would be appropriate. No additional invoice is necessary. Please provide in the space below the person to whom the cheque should be made payable, and the address.

**PLEASE WRITE LEGIBLY TO ASSIST US IN PROCESSING YOUR PAYMENT**

**TO BE COMPLETED FOR PAYMENT**:

Name of Patient:_____

Date form completed:_____ (dd/mm/yy)

Payment made payable to:_____

TREATING PHYSICIAN NAME (**PRINT)**:_____

TREATING PHYSICIAN ADDRESS:_____

_____

_____

_____

_____

_____

TELEPHONE: (  ) _____ FAX: (  ) _____

**FOR CANADIAN PACIFIC RAILWAY USE ONLY**

AMOUNT: ☐ $75 CANADIAN ACCOUNT:65802 INVOICE #:_____

☐ $100 CANADIAN

COCODE: 1000 ORDER # 7005727 ORDER: YES

**I HAVE READ AND APPROVE ACCORDING TO POLICY 6137**

SIGNATURE:_____ EMPLOYEE # 964936

**Fax the completed form to CP Occupational Health Services (OHS) at (403) 319-6803**

# Return To Work Program Pamphlet

**If you are injured or become ill it is your responsibility to:**

- Report all work-related injuries and illnesses immediately to your FLM/Supervisor.
- Report all absences related to non-occupational injuries or illnesses immediately to your FLM/Supervisor in the prescribed manner.
- See your physician for appropriate care and treatment and to determine when participation in the Return to Work program is appropriate.
- Advise the treating physician that the FAF should be completed during the office visit so that it may be returned to the workplace by fax or by hand **within seventy- two (72) hours**.
- If the FAF is not completed during the doctor's visit, you must follow-up with the doctor to ensure that the form is faxed to the appropriate recipient in a timely manner.
- Comply with recommendations of treatment provider(s).
- Attend all medical or rehabilitation appointments as required.
- While participating in the Return to Work program, maintain regular contact with your physician and FLM/Supervisor advising of progress or concerns and working together to make adjustments as necessary to ensure every opportunity for your successful return to work.
- If unable to continue with the return to work plan, provide and outline reasons for discontinuing by providing supporting documentation in a timely manner i.e. updated Functional Abilities Form.
- For injuries that result in lost time, maintain contact by telephone with your FLM/Supervisor at least once per week.
- Supply updated medical assessments (in the form of Functional Abilities Forms, physician notes, WCB/WSIB physician reporting forms, etc) to your FLM/Supervisor as requested by your FLM/Supervisor.