# LEAVE OF ABSENCE (LOA) Healthcare Provider Statement

NOTICE TO PROVIDER: This Michaels of Canada LLC Team Member (patient) has requested Medical Leave for a serious health condition that they or an immediate family member have. Completion of this form is necessary to determine whether the employee's requested time off is reasonable and protected by provincial statutes covering Leave(s) of Absence.

## PART 1 | To be completed by the TEAM MEMBER

Name _____

Date of Birth _____ Leave Type _____

I understand that the information requested on this form is required to assess my entitlement to a Leave of Absence from my employer and/or my suitability to return to my job. To protect the confidentiality of my personal information, access to my Canadian Benefits Management Limited file information will be restricted to:

- authorized employees and agents of Canadian Benefits Management Limited;
- to my employer if in the opinion of Canadian Benefits Management Limited the information is necessary to protect the health and safety of the work place; or
- to my employer but only to the extent required to communicate the decision about my entitlement to a Leave of Absence, or my ability to return to my job; or if I dispute the decision of Canadian Benefits Management Limited and I wish to escalate the matter to my employer. For these purposes my employer will not be given my medical diagnosis unless it is necessary and I provide an additional specific authorization to that effect.

I hereby authorize any health care provider to release all medical information in its possession, including physician's records, consultants' reports, hospital records and test results, pertaining to me to Canadian Benefits Management Limited. I also authorize Canadian Benefits Management Limited to collect, use, and disclose this information and other information in its possession to my health care providers, with my Short Term Disability (STD) Insurance provider, and with my Long Term Disability (LTD) Insurance provider(s), should my claim extend into the LTD period.

_____ _____

Signature Date

## PART 2: To be completed by Physician / Dentist / Clinical Psychologist

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|---|---|---|---|
| Is the Team Member your patient? Yes ☐ No ☐ | | | |
| If No and the LOA relates to the health of a third party, what is their relationship to the Team Member? | | | |
| Date illness began or date symptoms first appeared: | dd/mm/yyyy | Date absence from work began: | dd/mm/yyyy |
| Date of first attendance with you for this absence: | dd/mm/yyyy | Date of Return to Work: | dd/mm/yyyy |
| Will this illness require intermittent absences? Yes ☐ No ☐ | | If yes, please elaborate: | |
| List objective findings: | | | |
| Diagnoses: | | | |
| Is the patient at risk for harm to self or others within the workplace? Yes ☐ No ☐ | | | |

Professional Name (please print): _____

Professional Type
(Physician/Dentist/Clinical/Psychologist): _____

Address _____

Phone Number _____ Fax Number _____

Signature _____ Date _____

NOTE TO PHYSICIAN: CBML medical staff may contact your office on behalf of Michaels of Canada LLC if additional information about this release is required. Michaels of Canada LLC may require a fitness for duty evaluation before employee returns to work. Physicians signature required for all return to work releases.

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If you require assistance: Telephone 1-844-636-9622 FAX: 1-866-629-7894