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 Toll Free: 1-800-637-0024 www.optrust.com

MEDICAL EXAMINATION REPORT

INSTRUCTIONS: 1. Complete this side first.
 2. Complete reverse side.

OPSEU Pension Trust Fiducie du régime de
 retraite du SEFPO

APPLICANT'S DATA

Employee Last Name	First Name	Initial	Social Insurance Number		
Home address: No. and Street			Apt. No.		
City	Province	Postal Code	Date of Birth		
			DD	MM	YY
Ministry/Agency, Board, Commission		Position	Last day of work		
			DD	MM	YY

Personal information is collected on this form under the authority of Article 14.1 of the Ontario Public Service Employees' Union Pension Plan. It will be used to determine eligibility for benefits and to document/process pension payments. Questions about this collection should be directed to the Director, Member and Pensioner Services, 12th Floor, 1 Adelaide Street East, Toronto, Ontario M5C 3A7, Telephone (416)681-6100, Toll Free within Ontario 1-800-637-0024.

MEMBER'S CONSENT TO RELEASE MEDICAL INFORMATION

I AUTHORIZE any physician, medical practitioner, employer representative, agency providing disability benefits, hospital, clinic, other medical or medically related facility or insurance company, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment or test of me, to give to the OPSEU Pension Trust, its medical consultant, or its legal representative, any and all such information.

I AUTHORIZE the medical consultant to use this information to make a recommendation to the OPSEU Pension Trust regarding my application for a pension.

I UNDERSTAND the information obtained by use of this authorization will be used by the OPSEU Pension Trust in the evaluation of my claim for disability benefits only. Any information obtained will not be released by the OPSEU Pension Trust EXCEPT to persons or organizations performing business or legal services in connection with my claim, or as may be otherwise lawfully required or as I may further authorize.

This Authorization or any photographic copy of it shall be valid during the continuation of the claim.

Signature of Applicant _____ Date _____

TO PHYSICIAN: The applicant is applying for disability benefits from the OPSEU Plan. Please complete all sections and stroke out non-applicable areas. In order to help the applicant, provide precise details. It is important to review the accompanying job description and Physical Demands Analysis prior to completing this report.

ATTENTION: This form may be mailed directly to the OPSEU Pension Trust or given to the Applicant at the physician's discretion.

1. HISTORY

(a) When did symptoms appear or accident happen?	DD	MM	YY
(b) Date medical condition commenced?	DD	MM	YY
(c) Has applicant ever had same or similar condition? If "YES", state when and describe.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
(d) Is condition due to injury or sickness arising out of applicant's employment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> UNKNOWN
(e) Describe any Pre-existing Physical/Medical impairment:			
(f) Give name, address and telephone number of other treating physicians:			
(g) IMPORTANT: Attach copies of all relevant investigation and consultation reports.			

2. FINDINGS

Cardiac (if applicable)	
(a) Functional capacity	(b) Blood Pressure (latest visit) _____ Systolic/Diastolic
<input type="checkbox"/> Class 1 (no limitation)	
<input type="checkbox"/> Class 2 (mild limitation)	
<input type="checkbox"/> Class 3 (marked limitation)	
<input type="checkbox"/> Class 4 (complete limitation)	

Visual Impairment (if applicable)				
(a) What was vision at latest observation:		O.D.	O.S.	
	(i) With glasses			
	(ii) Without glasses			
(b) Vision can be restored in whole or in part by:				
<input type="checkbox"/> O.D.	<input type="checkbox"/> Lenses	<input type="checkbox"/> Treatment	<input type="checkbox"/> Operation	<input type="checkbox"/> Not restorable
<input type="checkbox"/> O.S.	<input type="checkbox"/> Lenses	<input type="checkbox"/> Treatment	<input type="checkbox"/> Operation	<input type="checkbox"/> Not restorable

3. DIAGNOSIS

(a) Diagnosis (including any complications)
Primary
Secondary (if applicable)
(b) Subjective symptoms
(c) Objective findings. Please specify and describe the findings of any special tests including results of current x-rays, E.K.G.'s or any other relevant tests.
OTHER FINDINGS (please specify)

4. TREATMENT

(a) Date of first visit:	DD	MM	YY	(b) Date of latest visit:	DD	MM	YY
(c) Frequency:	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Other (specify)				
(d) Is applicant following recommended treatment program?	<input type="checkbox"/> YES	<input type="checkbox"/> NO					
(e) Please specify drug treatment in progress if applicable.							
(f) What treatment, if any, do you recommend?							
(g) Has applicant been examined by certified specialist?				<input type="checkbox"/> YES	<input type="checkbox"/> NO		
If "YES", please provide name and address of specialist and dates examined.							
(h) Describe therapy and projected duration of treatment program.							
(i) Date and description of surgery, (if applicable).	DD	MM	YY				

Keep a copy of this form for your records.

5. PROGRESS

Has applicant: Recovered Improved Not Improved Retrogressed?

6. PHYSICAL/MENTAL INCAPACITY

(a) Is the applicant's physical/mental incapacity:

PROLONGED - means the impairment must have lasted for a period of a least 12 continuous months.

DEGREES OF RESTRICTION in the activities of daily work can generally be classified as MILD, MODERATE, MARKED or SEVERE

A MILD LIMITATION is one in which the restriction resulting from the mental or physical impairment is such that, in the absence of treatment or aids, the individual is not prevented from, or is only rarely or intermittently restricted by the impairment in the performance of, or where the continuous use of aids (eg. eye glasses, hearing aids, etc..) or medications restores full or nearly full competence in the performance of the activities or duties of his/her position.

A MODERATE LIMITATION is one in which the restriction resulting from the mental or physical impairment is such that aids or medications fail to produce sufficient compensation of the impairment, with the result that the individual experiences great difficulty in the regular duties of his/her position, but is still capable of working with little reliance on other persons in the performance of his/her duties.

A MARKED LIMITATION is one in which aids or medications substantially fail to produce sufficient compensation of the impairment with the result that the individual experiences great limitations on his/her ability to perform the duties of his/her position.

SEVERE - means the impairment **markedly** restricts the person's performance of regular duties. What must be considered is not so much the presence of an ailment or condition, but rather how the condition/impairment **affects** the person's ability and capacity to perform the regular duties of his/her position.

(b) Biomechanical Limitations:

(c) Neuropsychological Limitations:

Note: Refer to attached physical demands analysis for essential duties of position.

7. EFFECT OF PHYSICAL OR MENTAL INCAPACITY ON ESSENTIAL DUTIES

Please explain the extent to which the applicant's illness or injury affects his or her capacity to:

(a) perform his or her regular duties

(b) perform the duties of a similar position in the same job class

(c) perform his/her duties of a similar position in the same class, with modifications or accommodations?

(d) If applicable, please specify possible physical/medical accommodations

(e) Can you suggest a suitable alternative position in the same class given applicant's possible physical mental incapacity?

(f) Is applicant a suitable candidate for any other employment?

(g) Is applicant a suitable candidate for vocational counselling?

(h) Is retraining recommended?

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8. PROGNOSIS

(a) Is applicant now unable to perform his/her duties?	For Regular Position: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> With modification <input type="checkbox"/> Without modification	Similar Position -same Class & Grade: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> With modification <input type="checkbox"/> Without modification
If "NO", when was applicant able to resume work?	DD MM YY	DD MM YY
If "YES", when should applicant be able to resume work?	DD MM YY	DD MM YY
(b) If indefinite, the estimated number of additional weeks/months before applicant's return ----- weeks ----- months		
(c) If "YES", or indefinite, is applicant a suitable candidate for some form of trial modified employment? <input type="checkbox"/> YES <input type="checkbox"/> NO		
(a) Is applicant a suitable candidate for trial employment?	For Regular Occupation: <input type="checkbox"/> YES <input type="checkbox"/> NO	Any Other Occupation: <input type="checkbox"/> YES <input type="checkbox"/> NO
If "YES", when could trial employment commence:	DD MM YY <input type="checkbox"/> Full Time _____	DD MM YY <input type="checkbox"/> Part-time _____
If "NO", please explain:		
(b) Would vocational counselling and/or retraining be recommended? <input type="checkbox"/> YES <input type="checkbox"/> NO		

REMARKS

Physician's Name (Print)	Certified Specialist? <input type="checkbox"/> YES <input type="checkbox"/> NO	If "YES", indicate specialty
Address		
City	Province	Postal Code
Signature		Telephone No. () - .
		Date

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