EMPLOYEES, PHYSICIANS, HEALTH CARE PROVIDERS
IMPORTANT- YOU MUST READ

TO EMPLOYEES

The attached form is used by ILWU Local 500 to determine requests by employees to maintain their position on the causal boards when they are unable to work due to injury or illness.

Please complete section 1 and take section 2 to your doctor or health care provider to complete. Incomplete forms or missing information may result in ILWU Local 500 rejecting your request. If you have a mental health issue (stress, anxiety, etc.) that requires a work restriction or for you to be off work, a mental health professional must complete your form. Forms submitted after board moves have commenced WILL NOT BE ACCEPTED.

You must renew your request and provide ILWU Local 500 with an updated form within one week of the end of the period of illness or injury identified by your physician or health care provider. If your period of illness or injury is 90 days or more, you must renew your request by providing an updated form within one week of the expiry of 90 days that you are unable to work. Failure to provide an updated form may result in demotion to a lower board.

ILWU Local 500 will not maintain your position on the boards for periods that you are working in another industry. You must inform ILWU Local 500 if you take employment (including self-employment) outside of the industry during a period in which you are requesting your position on the boards be maintained.

This form is **only** used to request that ILWU Local 500 maintain your position on the boards during injury and illness. If you are seeking an accommodation at work, you must make that request to the medical exemption committee. If you are seeking weekly indemnity or credited time, you must make that request to WEBC.

Falsifying reports, or submitting a request for a period during which you are working in another industry, may result in discipline up to and including deregistration.

TO PHYSICIANS OR HEALTH CARE PROVIDER

Please complete section 2 of the attached form and return it to the patient to provide to ILWU Local 500. ILWU Local 500 does not accept handwritten prescription pad notes. The employee is responsible for any cost associated with you completing the certificate.

If the patient has a mental health issue that requires the patient to be off work, a mental health care provider must complete the form. ILWU Local 500 is seeking the patient's prognosis, but in most cases, this does not require a diagnosis.

Only the ILWU Local 500 form will be accepted and placed in the employee's file for consideration, however typed letters and/or reports submitted by an attending physician or health care provider can be attached to the certificate.

SECTION 1 – EMPLOYEE INFORMATION (to be completed by worker)		
Employee Full name	**Employee Home Address**	**Work #**
Ratings held:		

Yes No

Are you employed outside the industry? (including self employed) ☐ ☐

I acknowledge that by completing and returning this form to the Union I am requesting that my position on the boards be maintained because of an injury or illness.

I understand that I cannot make this request for a period of time that I am working outside the industry. I certify that I am not working outside of the industry for the period of this request, and if I do take employment outside of the industry, I will inform the Union immediately.

I understand that it is my responsibility to renew my request within one week of the end of the period of time that my health care provider has stated I am expected to be unable to work, or if the period of time I am unable to work is 90 days or greater, then within one week of the expiry of 90 days. I understand that if I do not renew my request I may be demoted to a lower board.

I certify that the information provided by me to my health care providers and by me in this form is accurate and that I am not seeking to maintain my position on the boards while I am working outside the industry.

I understand that I may be subject to discipline for providing misleading information to the Union.

I hereby give permission to the Union to use the information provided in this form to

- ensure the safety of myself and co-workers;
- determine my fitness for work and my placement on the boards;
- disclose this information with employers and/or the BCMEA if necessary because the Union is seeking an accommodation for me; and
- contact my health care providers to seek additional information if necessary.

Employee signature: _____ Date: _____

SECTION 2 – MEDICAL INFORMATION (to be completed by treating Physician or Health Care Provider)

PART A – NATURE OF ILLNESS OR INJURY

Date of first symptoms	Date of first treatment	Date of first work absence due to illness/injury	Date of Examination
Day /Month/Year	Day/Month/Year	Day/Month/Year	Day/Month/Year

1. Is the patient presently totally disabled from performing longshoring work due to:

	Yes	No
physical restriction?	☐	☐
mental health restriction?	☐	☐
If mental health restriction, are you a mental health professional?	☐	☐

2. If the patient is not totally disabled from performing longshoring work,

How many 8 hour shifts per week is the patient presently medically able to work? _____

PART B – DURATION OF INABILITY TO WORK

3. What is the expected duration of the patient's illness or injury? If you cannot provide a date, please give an estimate in days, weeks, or months.

4. When is the patient expected to be medically able to resume full time work?

PART C – RECOVERY AND RETURN TO WORK
5. Are you the primary health care provider treating / monitoring the patient?
6. Has the patient been prescribed treatment recommendations / treatment plan?
7. Is the patient following treatment recommendations / treatment plan?
8. Will the patient be fit to perform safety sensitive work upon recovery?
9. Does the patient require a gradual return to work?
10. What return to work schedule do you recommend (including duration)?

PART D – HEALTH CARE PROVIDER'S SIGNATURE AND STAMP	
Date of certificate	**Health Care Provider's stamp and signature**
Health Care Provider's Name and Title	