BRITISH COLUMBIA
BC Public Service
Where ideas work

APPLICATION TO THE REHABILITATION COMMITTEE

The joint Employer/Union Rehabilitation Committee is designed to encourage and facilitate the early return to gainful employment of employees who have been ill or injured. The Rehabilitation Committee reviews your return to work plan and makes recommendations to the ministry as your rehabilitation progresses. The Rehabilitation Committee helps the ministry by making resources available to help you return to work. This application is to be completed by:

a) all employees returning to work on a trial basis under section 1.03(d) of the Short Term Illness or Injury Plan (STIIP).
b) all employees who have been accepted under the Long Term Disability Plan.
c) employees who are unable to perform the duties of their own occupation due to illness or injury, and circumstances suggest placement into another position may be warranted.

INSTRUCTIONS FOR COMPLETING APPLICATION

1. Section A, B & C of the form are to be completed jointly, whenever possible, by the applicant and their manager/supervisor and/or human resources personnel and sent to the Secretary, Rehabilitation Committee.
2. Section F is to be completed by the applicant's attending physician or specialist and sent in the pre-addressed envelope to the Secretary, Rehabilitation Committee.
3. Where the ministry, based on existing available medical information, considers the employee disabled to the extent that he/she is expected to never be able to perform the duties of any substantial gainful occupation, the application is to be returned to the Secretary, Rehabilitation Committee with a report explaining why.

Freedom of Information and Protection of Privacy Act (FOIPPA) The personal information requested on this form is collected under the authority of *FOIPPA* s.26(c) and will be used to process your application to the Rehabilitation Committee. Questions about the collection or use of this information can be directed to an HR Service Representative at the BC Public Service Agency by submitting a request at AskMyHr, phoning 1-877-277-0772, or writing to: Manager, Contact Center Operations, BC Public Service Agency, 810 Blanshard Street, Victoria BC V8W 2H2.

PURPOSE OF APPLICATION

☐ STIIP TRIAL (1.03D) – *Complete sections A & B*
☐ EMPLOYEE ACCEPTED ON LTD – *Complete sections A, B, C, D & E*
☐ APPLICATION FOR ALTERNATE EMPLOYMENT DUE TO MEDICAL REASONS – *Complete sections A, B, C, D & E*

SECTION A: EMPLOYEE INFORMATION

NAME	GENDER (statistical purposes only) ☐ MALE ☐ FEMALE	DATE OF BIRTH YYYY / MM / DD	SOCIAL INSURANCE NO.
CURRENT ADDRESS – *Include city, province, postal code*			HOME PHONE NO. / WORK PHONE NO.
EMPLOYING MINISTRY	BRANCH / WORK ADDRESS – *Include city, prov., postal code*		
SENIORITY DATE YYYY / MM / DD	PRESENT CLASSIFICATION	GRID LEVEL / BI-WEEKLY RATE OF PAY	UNION / ASSOCIATION ☐ REGULAR ☐ AUXILIARY
LAST DAY WORKED YYYY / MM / DD	BENEFIT START DATE YYYY / MM / DD	WHICH OF THE FOLLOWING BENEFITS ARE YOU CURRENTLY RECEIVING ☐ STIIP ☐ LTD ☐ CPP DISABILITY ☐ WCB	WCB CLAIM NO. – if applicable
NAME OF ATTENDING PHYSICIAN	PHYSICIAN ADDRESS – *Include city, prov., postal code*		PHONE NO.

WHY ARE YOU UNABLE TO PERFORM THE FULL DUTIES OF YOUR JOB?

EMPLOYEE AUTHORIZATION

I hereby authorize my physicians/specialists, Occupational Health Programs (doctors and nurses) and all rehabilitative agencies to release any relevant information as requested by members of the Rehabilitation Committee for the purpose of return to work planning. However, this is not an admission that I am able to pursue substantial gainful employment.

APPLICANT'S SIGNATURE — DATE SIGNED YYYY / MM / DD

X

SECTION B – To be completed by applicant's manager/supervisor and/or human resource/personnel officer or designate as appropriate.

PLEASE PROVIDE BACKGROUND TO THE CASE AND ANY SPECIAL CIRCUMSTANCES YOU ARE AWARE OF – Attach a separate sheet if necessary

WHAT ACTIONS HAVE TAKEN PLACE TO DATE? (E.G. MINISTRY COUNSELLING, TRAINING, SKILL TESTING, JOB SEARCHES, ETC.)

LIST SUGGESTED CLASSIFICATIONS/POSITIONS THAT THE EMPLOYEE MAY BE CONSIDERED FOR IF ALTERNATE EMPLOYMENT IS NECESSARY.

MANAGER/SUPERVISOR OR HUMAN RESOURCE/PERSONNEL OFFICER SIGNATURE | PRINT NAME | DATE SIGNED YYYY / MM / DD

X

SECTION C: SUMMARY OF EMPLOYEE'S EDUCATION, TRAINING AND EXPERIENCE

PREVIOUS JOB EXPERIENCE – INCLUDE DATES AND A BRIEF DESCRIPTION OF DUTIES

OTHER EMPLOYMENT INTERESTS

OTHER INTERESTS AND HOBBIES

LIST CLASS(ES) OF VALID DRIVER LICENSE	LICENCE RESTRICTIONS

ADDITIONAL EDUCATION & TRAINING

Describe secondary, post secondary, courses and training.
Start with highest level achieved and specify the degrees, certificates or diplomas completed.

NAME OF INSTITUTION OR ORGANIZATION	LOCATION	DATES OF ATTENDANCE	AREA OF STUDY / COURSE	GRADE / CERTIFICATION / DIPLOMA / DEGREE	(✔) Completed? YES	NO
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐

SKILLS / EXPERIENCE

Check (✔) areas of skills / experience.

- ☐ TYPING WPM _____
- ☐ DATA ENTRY
- ☐ DICTATING EQUIPMENT
- ☐ SWITCHBOARD
- ☐ CALCULATOR
- ☐ CASHIER
- ☐ ACCOUNTS (AR/AP)
- ☐ PAYROLL
- ☐ WORD PROCESSING – *specify* _____
- ☐ COMPUTER SYSTEM SOFTWARE – *specify* _____
- ☐ COMPUTER SYSTEM HARDWARE – *specify* _____

SECTION D: JOB INFORMATION SUMMARY – To be completed by applicant's manager/supervisor and/or human resource/personnel officer or designate as appropriate.

EMPLOYEE'S JOB TITLE	HOW LONG HAS THE EMPLOYEE WORKED IN THIS POSITION? YEARS	MONTHS

LIST THE DUTIES IN THIS JOB AND THE PERCENTAGE OF TIME EACH TAKES PER WEEK – *Attach an additional sheet if required*

DUTIES	PERCENTAGE OF TIME	DUTIES	PERCENTAGE OF TIME

WORK ENVIRONMENT

Does the employee's job require work in any of the following conditions?

	YES	NO	NO. OF TIMES PER DAY	NO. OF HOURS PER DAY
Outside	☐	☐		
In extremes of cold or heat	☐	☐		
In a damp or humid environment	☐	☐		
In a noisy environment	☐	☐		
In dusty or unventilated environment	☐	☐		
In toxic fumes	☐	☐		
Does job involve handling chemicals	☐	☐		

If yes, please list:

STRENGTH

Does the job require the employee to lift or carry:

	YES	NO	NO. OF TIMES PER DAY	NO. OF HOURS PER DAY
More than 50 lbs.	☐	☐		
More than 20 lbs.	☐	☐		
More than 10 lbs.	☐	☐		

MOBILITY

Does the job involve:

	YES	NO	NO. OF TIMES PER DAY	NO. OF HOURS PER DAY
Bending/Crouching/Kneeling/Crawling	☐	☐		
Sitting	☐	☐		
Standing	☐	☐		
Walking	☐	☐		
Climbing	☐	☐		
Driving	☐	☐		
Remaining in one position for more than 1 hour	☐	☐		
Reaching above shoulder height	☐	☐		
Reaching at shoulder height	☐	☐		
Reaching below shoulder height	☐	☐		

DEXTERITY

How much of the employee's work requires:

Finger dexterity?	Right Hand	_____%
	Left Hand	_____%
Hand dexterity?	Right Hand	_____%
	Left Hand	_____%

VISION

How much of the employee's work requires:

Sharpness of vision?	Near	_____%
	Far	_____%
Colour discrimination?		_____%

COMMUNICATION

How much of the employee's time is spent:

Talking	_____%
Writing	_____%
Supervising other people	_____%

EQUIPMENT USE – List any office machines, tools or other equipment that the employee uses in this job.

TYPES OF EQUIPMENT	NO. OF TIMES PER DAY	NO. OF HOURS PER DAY	TYPES OF EQUIPMENT	NO. OF TIMES PER DAY	NO. OF HOURS PER DAY

MANAGER/SUPERVISOR OR HUMAN RESOURCE/PERSONNEL OFFICER SIGNATURE

DATE SIGNED YYYY / MM / DD

X

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APPLICATION TO THE REHABILITATION COMMITTEE
PHYSICIAN'S REPORT

SECTION E – To be completed by applicant's manager/supervisor and/or human resource/personnel officer or designate as appropriate.

EMPLOYEE NAME		SOCIAL INSURANCE NO.
ADDRESS	CITY	POSTAL CODE
EMPLOYING MINISTRY	UNION / ASSOCIATION	APPLICATION DATE YYYY / MM / DD

EMPLOYEE AUTHORIZATION – I hereby authorize my physicians/specialists to release any relevant information as requested by members of the Rehabilitation Committee for the purpose of return to work planning.

EMPLOYEE'S SIGNATURE

X

DATE SIGNED YYYY / MM / DD

INFORMATION TO PHYSICIAN

Your patient has submitted an application to the Joint Union/Employer Rehabilitation Committee with the Province of British Columbia on the basis of a medical condition which may have rendered him/her currently incapable of performing the full duties of his/her current occupation. The Rehabilitation Committee has the responsibility for reviewing applications for alternate employment and must determine:

1. If your patient is requesting alternate employment on medical grounds, whether the application meets the criteria of the Rehabilitation Committee.
2. Whether your patient is capable of performing alternate substantial gainful, productive full-time employment now or in the future.
3. Whether rehabilitative employment is appropriate now or in the future and what form this may take.

Your patient has authorized you to complete the form to enable the Rehabilitation Committee to review his/her application.

Your assistance is very much appreciated.

Please forward this report to:

Secretary, Rehabilitation Committee
BC Public Service Agency
PO Box 9404 Stn Prov Govt
Victoria BC V8W 9V1

SECTION F – To be completed by Physician

LAST EXAMINATION DATE YYYY / MM / DD

Is the patient's disability:

☐ PERMANENT ☐ TEMPORARY ☐ RECURRENT

SUMMARY OF FINDINGS – *INCLUDING PROGRESSION OF DISABILITY*

Is your patient currently capable of performing the full duties of his/her own occupation as described on the reverse?

☐ YES ☐ NO

If no, will your patient be able to return to the full duties of his/her own occupation in the future following treatment and/or convalescence?

☐ YES ☐ NO

If no, will your patient be able to return to other gainful, productive employment? ☐ YES ☐ NO

When could rehabilitation or a return to work plan commence? YYYY / MM / DD

What limitations or restrictions would you advise for your patient in relation to returning to other gainful, productive employment?

Additional comments:

PHYSICIAN'S NAME	ADDRESS	CITY	POSTAL CODE

PHYSICIAN'S SIGNATURE

X

DATE SIGNED YYYY / MM / DD