Medical Examination Report

Public Service Pension Plan (PSPP)

Complete page 1 before forwarding this form, a copy of your job description, and the accompanying Physical Demands Analysis to your physician.

OPB client number

OPB client information

OPB client last name (please print) | OPB client first name | Initials

Apt. number | Street address

City | Province | Postal code | Birth date (YYYYMMDD)

Employer name

Current position title | Last date of work (YYYYMMDD)

Sign and date (keep copies of all completed forms for your records)

I authorize OPB to release my medical information to OPB's medical consultants, solely for the purpose of evaluating my claim for disability benefits. For this purpose, I also authorize medical consultants to release my medical information to OPB.

Date signed (YYYYMMDD) | Contact telephone number

OPB client signature

Physician must complete pages 2 to 6 and return to you for filing with OPB.

The physician or medical professional signing this form must be recognized as such by the appropriate governing medical association in Canada or the USA (e.g., Canadian Medical Association, American Medical Association).

Please note: You are responsible for paying any fees required for completing this report.

The personal information on this form is collected under the authority of the *Public Service Pension Act* and will be used only to administer pension benefits. For more information or if you have any questions, contact Client Services or our Privacy Officer at:

Telephone: 416-364-5035 or **toll free** 1-800-668-6203 (Canada & USA) | **Fax:** 416-364-7578 | **OPB.ca**

Ontario Pension Board 200 King Street West, Suite 2200, Toronto ON M5H 3X6

Medical Examination Report

Public Service Pension Plan (PSPP)

Physician - complete pages 2 to 6. The applicant is either applying for disability benefits from the Public Service Pension Plan or has been asked to have their medical condition reassessed. Complete all sections and strike out non-applicable areas. Before completing this report, review the accompanying job description and Physical Demands Analysis. To help the applicant, give precise details. Return completed form to the applicant.

OPB client number

1. History

a) When did symptoms appear or accident happen?

Date (YYYYMMDD)

b) When did medical condition start?

Condition started (YYYYMMDD)

c) Has applicant ever had the same or similar condition? ☐ Yes ☐ No ☐ Unknown

If yes, state when and describe

d) Is condition due to injury/sickness arising from applicant's employment? ☐ Yes ☐ No ☐ Unknown

e) Describe any pre-existing physical/medical impairment:

f) Provide name, address and phone number of any other treating physicians:

2. Findings

Cardiac (if applicable)

a) Functional capacity:

☐ Class 1 (no limitation) ☐ Class 2 (mild limitation)

☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

b) Blood pressure (latest visit):

Systolic/Diastolic

Visual Impairment (if applicable)

a) What was vision at latest observation?

With glasses: O.D. O.S. Without glasses: O.D. O.S.

b) Vision can be restored in whole or in part by:

☐ O.D. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

☐ O.S. ☐ Lenses ☐ Treatment ☐ Operation ☐ Not restorable

OPB client number

3. Diagnosis

a) Diagnosis (including any complications)

Primary

Secondary (if applicable)

b) Subjective symptoms

c) Objective findings. Specify and describe the findings of any special tests including results of current x-rays, EKGs, or any other relevant tests.

Other findings (please specify)

4. Treatment

a) Date of first visit (YYYYMMDD)

b) Latest visit (YYYYMMDD)

c) Frequency: ☐ Weekly ☐ Monthly ☐ Other (specify):

d) Is applicant following recommended treatment program? ☐ Yes ☐ No

e) Specify drug treatment in progress, if applicable

f) What treatment, if any, do you recommend?

g) Has applicant been examined by a certified specialist? ☐ Yes ☐ No

If yes, provide name, address of specialist and dates examined

OPB client number

4. Treatment (continued)

h) Describe therapy and projected duration of treatment program

i) Description of surgery, if applicable:

Surgery date (YYYYMMDD)

5. Progress

Applicant has: ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

For sections 6, 7 and 8, refer to attached Physical Demands Analysis for essential duties of the job position

6. Physical/mental incapacity

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

☐ **Prolonged** (means the impairment must have lasted for a period of at 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 (e.g., 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) Biomedical limitations

c) Neurophysical limitations

OPB client number

7. Effect of physical/mental incapacity on essential duties

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

a) perform his/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, specify possible physical/medical accommodation

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

f) Is applicant a suitable candidate for any other employment? ☐ Yes ☐ No

g) Is applicant a suitable candidate for vocational training? ☐ Yes ☐ No

h) Is retraining recommended? ☐ Yes ☐ No

8. Prognosis

a) Is applicant unable to perform his/her regular duties?

For regular position: ☐ Yes ☐ No ☐ With modification ☐ Without modification

Similar position (same class & grade): ☐ Yes ☐ No ☐ With modification ☐ Without modification

If 'no', when was applicant able to resume work?

Regular position (YYYYMMDD) | Similar position (YYYYMMDD)

If 'yes', when should applicant be able to resume work?

Regular position (YYYYMMDD) | Similar position (YYYYMMDD)

b) If indefinite, the estimated number of additional weeks/months before applicant's return:

Weeks | Months

OPB client number

8. Prognosis (continued)

c) If yes, or indefinite, is applicant a suitable candidate for some form of trial modified employment?

☐ Yes ☐ No

d) Is applicant a suitable candidate for trial employment?

Regular occupation: ☐ Yes ☐ No

Any other occupation: ☐ Yes ☐ No

If yes, when could trial employment start?

Regular occupation: ☐ Full-time ☐ Part-time

Any other occupation: ☐ Full-time ☐ Part-time

If no, please explain

e) Would vocational counselling and/or retraining be recommended? ☐ Yes ☐ No

Remarks

Sign and date

Physician last name (please print) | Physician first name | Initials

Office address

City | Province | Postal code | Country (if outside Canada)

Certified specialist? ☐ Yes ☐ No

If yes, indicate specialty

Date signed (YYYYMMDD)

Office telephone

Physician signature

The physician or medical professional signing this form must be recognized as such by the appropriate governing medical association in Canada or the USA (e.g., Canadian Medical Association, American Medical Association).

The applicant is responsible for paying any fees that you may charge for completing this report.