Dr. Jason Lo
A202-3000 Highway 7 East
Markham, Ontario
L3R 6E1

INVOICE

To: Morneau Shepell
50 Burnhamthorpe Rd. W, Suite 316
Mississauga, ON
CANADA L5B 3C2

Monday, November 30, 2020
Bill number JL105665

Re: Shareen Melissa Douglas
Apt-405
1535 Birchmount Rd
Scarborough, ON
m1p 2h2
DOB: Mar 7, 1986 F

Concerning: Back Pain

	Service Date	# Services	Amount
Sick Note: I700A	Nov 30, 2020	1	20.00

Amount Due: **20.00**

faxed on Nov 30.

MORNEAU SHEPELL

November 27, 2020

TO: ATTENDING PHYSICIAN

Re: Shareen Douglas

Your patient is an employee of Scotiabank and has informed us that they have sustained a non-occupational illness or injury that has resulted in an absence from work. Scotiabank is committed to providing employees with as much assistance and support as possible when dealing with health issues that may arise. Scotiabank's goal is to support employees and to get them back to work in the safest, most effective way possible, either in a modified capacity or to their regular employment duties.

Scotiabank has established a Disability Management Program to provide appropriate support to employees who are absent from work due to illness or injury; therefore, Scotiabank requires medical substantiation of an employee's medical need to be away from work, or when physical restrictions need to be accommodated. Morneau Shepell has been requested to manage the confidential medical information necessary to substantiate this need.

Morneau Shepell provides various support services such as counseling, community and professional service information as well as a number of physical and psychosocial health services that assist employees who have health concerns that may impact their ability to work. Morneau Shepell also provides Disability Management Services to Scotiabank employees.

Attached is an Attending Physician Form (APF) for you to complete and return it to **Morneau Shepell via FAX at 1-877-562-9126 or email dmdailyfaxes@morneaushepell.com**. This form will assist Morneau Shepell in determining support for the employee's absence from work. **As part of the Scotiabank policy guidelines and in order for the employee's eligibility for Short-term Disability benefits to continue, Morneau Shepell must receive the completed Attending Physician Form within 7 business days of the date of this letter.** If for some reason you cannot complete the form by the given date, please advise the employee so that they can advise the Morneau Shepell Case Manager. Please note that the patient is responsible for the Fees related to completion of the attached medical form.

In order to assist your patient, the information requested in the APF is essential for future return to work and Case Management planning.

We appreciate your time in responding to this request.

Regards,

Lisa Saint-Hilaire
Morneau Shepell
Phone 8445233483
Fax 877-562-9126
lshilaire@morneaushepell.com

MORNEAU SHEPELL

ATTENDING PHYSICIAN FORM

Please **return the attached form by email to: DMdailyfaxes@morneaushepell.com, MyAbiliti Application, by fax at Fax: 1-877-562-9126 or by mail to 50 Burnhamthorpe Road West, Suite 316 Mississauga, On L5B 3C2**

PART 1: To be completed by the applicant (patient):

PATIENT INFORMATION

Name: Shareen Douglas	**Date of Birth M/D/YY:** March 2, 1986
Employer: Scotiabank	**Job Title and Main Duties of the Job:** Customer Solutions Advisor

AUTHORIZATION

I authorize the release of medical information, including consultants' reports, hospital records and test results, pertaining to my present impairment/illness/disability to my employer's health service/consultants, as required. All information will be treated as Medically Confidential. I authorize my employer, and/or my employer's health service/consultant to share information with my health care provider.

Signature: Shareen Douglas Date: 11/30/20

PART 2: To be completed by Attending Physician

(Please note: in order to make a recommendation for your patient to receive income replacement benefits, we require objective medical findings to support the diagnosis. Please ensure the form is completed accurately and to the best of your ability).

STATEMENT OF IMPAIRMENT

Date illness began or symptoms first appeared : M/D/Y 11/8/20	Date absence from work began: M/D/Y 11/9/20	Date of first visit for this absence: M/D/Y 11/30/20 Dates of subsequent visits:

Primary Diagnosis: back strain

Secondary Diagnosis:

Severity: ☐ Mild ☐ Moderate ☑ Severe

Objective findings and test results: tenderness lower back, upper back. ☐ **Copies of results attached**

Subjective Symptoms: pain in upper back/ ~~upper~~ lumbar, shoulder

Has employee experienced the same or similar medical problem in the past? ☐ YES ☑ NO

If YES, explain:

Is this condition(s) due to:
☐ work related injury/illness ☐ pregnancy –EDD_____M/D/YY
☐ MVA ☐ Co-Morbid conditions exist: If yes, please specify or provide details.

TREATMENT

Names of other consulting or treating health care practitioners:

Other Treatment (i.e.: physiotherapy, group therapy) Type & Name of Facility – dates attended

CURRENT MEDICATIONS:

Name	Dose/Frequency	Start Date
Naprosyn	375 BID	

In-patient Hospital Admission: (include name of Institution, Admission, Discharge, Name of Admitting MD)

Is any surgery, investigative procedure or other therapy scheduled for the future? ☐ Yes ☑ No

If YES, please outline:

Date of scheduled surgery:

Is your patient following your treatment recommendations?
☑ Yes ☐ No

Is your patient's condition:
☑ improving ☐ unchanged ☐ deteriorating

RECOMMENDED WORK LIMITATIONS

MORNEAU SHEPELL

WORK CAPABILITY

In order to qualify for benefits, one must be 'unable to work as a result of illness or injury'. The company has a **MODIFIED WORK PROGRAM**, and will accommodate employees who may be unable to perform their normal job duties.

Please provide medical clarifications in the space below as to how the illness/injury results in an altered or inability to perform his/her work duties.

RESTRICTIONS

Please mark the appropriate box and circle left or right if applicable. Dominant Hand: ☐ Left ☐ (Right)

Shoulder/Arm/Forearm Movements:
- ☑ No work above shoulder height
- ☐ Limited reaching with left / right arm to < ___ inches.
- ☐ Limited reaching with left / right arm to < ___ min.
- ☐ Limited push/pull with left / right arm to < _____ pounds

Hand Movements:
- ☐ Limited grip/grasp with left / right hand to < ___ min.
- ☐ Limited forceful grip/grasp with left / right
- ☐ No use of left / right hand

Lifting Weights:
- ☑ No lifting floor to waist > 0 pounds
- ☑ No lifting waist to shoulder > 0 pounds

Lower Extremity Movements:
- ☑ Limited walking to < 0.05 hour per day
- ☑ Limited standing to < 0.5 hour per day
- ☐ Limited squat/kneel to < ___ min.
- ☑ No squatting/kneeling
- ☑ No job that requires stair climbing
- ☑ No climbing ladders

Back Movements:
- ☐ Limited twisting of waist to <45° to left / right
- ☐ Limited bending at waist to <45° forward
- ☐ Limited bending of waist to <90° forward
- ☐ Limited range of neck flexion to _____

No bending of back.

Respiratory Exposure:
- ☐ No jobs with direct exposure to smoke, dust, mist
- ☐ No exposure to solvents, petroleum distillates, etc.

Cognitive/Psychological:
- ☐ Problems relating to other people
- ☐ Difficulties performing simple and repetitive tasks
- ☐ Problems maintaining focus/concentration on the job
- ☐ Limited ability to perform complex and varied tasks
- ☐ Reduced energy and pace required for the job
- ☐ Problem responding appropriately to supervision and management

Other:
- ☐ Restrictions Related to Medications: specify _____
- ☐ Restrictions Related to operating a motor vehicle or mechanical equipment: specify _____

* Unable to work at all *

COMMENTS/SPECIFIC RESTRICTIONS:

no sitting > 30 minutes.

Is complete recovery expected? ☑ YES ☐ NO ☐ Unknown

Estimated duration of reduced capacity: total 4-8 week.

Return/Follow-up appointment date: _____

Name of attending physician: DR. JASON LO, M.D.		Specialty:
Address: Suite 202 3000 Hwy 7 East, Markham, ON L3R 6E1		
Number Street / City	Province	Postal Code
Phone Number: ( ) Tel: 905-480-1050	Fax Number : ( ) Fax: 905-480-0898	Email Address:
Signature:	Date: Nov 30/20	

Please return the attached form by mail to: 50 Burnhamthorpe Road West, Suite 316, Mississauga, On L5B 3C2, by fax at Fax: 1-877-562-9126, email at DMdailyfaxes@morneaushepell.com or by MyAbilitiApplication Name:

Shareen Douglas

Scotiabank

CONSENT TO SHARE PERSONAL INFORMATION

For the purposes set out below, by signing below, I consent to the release and sharing of:

1. Any of my personal information ("Information") that is collected or held by any health care practitioners or physicians and that relates in any way to any work absence or claim due to a medical or health condition to Morneau Shepell Ltd. (for non-occupational illnesses and injuries) and RMS Canada (for occupational illnesses and injuries) (collectively "Service Providers" to the Bank of Nova Scotia and its affiliates ("Scotiabank")).
2. Any of my Information that is collected or held by Scotiabank that relates in any way to any work-related absence or claim.
3. *Information may be shared between Service Providers, Scotiabank, any independent evaluators, agents, Short-term or Long-term* Disability benefit payers, and consultants acting on behalf of Scotiabank or its Service Providers, including Gowan Consulting.

Information may be shared verbally, in writing or electronically, and includes, but is not limited to:

- Personal contact information
- Medical/health information
- Work performance information or other work-related information
- Results of any consultations or assessments

I understand that this consent to release and share my Information is necessary for the purposes of:

- Providing information concerning my absence or inability to perform the essential duties/hours of my role;
- Planning and managing my return to work, including but not limited to rehabilitation and accommodation;
- Providing documentation and/or information to a provincial Worker's Compensation Board, or equivalent;
- Obtaining and/or scheduling independent medical evaluations and/or assessments;
- Adjudicating, evaluating and managing my claim for disability benefits;
- Compiling statistical information or audit purposes; or,
- Assessing and managing potential or actual litigation, a grievance, a claim under human rights legislation and any other legal claims or demands ("a Dispute").

I understand Scotiabank will receive all information in relation to my claim or absence, including clinical notes and medical diagnosis information: a) if required in connection with a Workers' Compensation claim or equivalent (in which case Scotiabank's occupational health specialists or their Service Provider would receive all information in relation to the claim or absence) b) in the event of any Dispute or, c) if otherwise required by Scotiabank legal counsel.

AUTHORIZATION TO DEDUCT PAYMENTS

I understand that if I receive an overpayment of disability benefits for any reason whatsoever, including, but not limited to the following circumstances, I must reimburse Scotiabank the amount of the overpayment ("Overpayment"):
(a) My application for Short-term Disability benefits is declined; or
(b) If another organization is responsible for my disability and I recover funds for salary loss through a third party (i.e. due to legal proceedings, automobile insurance, etc.)

By signing below, I authorize Scotiabank, in its sole discretion, to deduct from any amounts owing to me (including my wages, salary, incentive and commission payments) or collect from my Scotiabank bank account set up for payroll purposes, whether held solely or jointly, any:

- Required premiums necessary to pay for my selected benefits coverage if my Short-term Disability claim is declined; and,
- *Overpayment amounts for which I fail to reimburse Scotiabank*

This Consent and Authorization is valid from the Effective Date below for a period of two (2) years or until I return to my regular and full time duties, whichever is longer.

A photocopy or facsimile of this Consent and Authorization shall be as valid as the original, and must be signed and returned to Morneau Shepell or RMS Canada no later than 7 business days after receipt *as a condition of participation in Scotiabank's disability management program.*

Name of Employee: SHAREEN DOUGLAS (print)
Signature of Employee: Shareen Douglas
Effective Date: NOVEMBER 30, 2020
Employee address: 405 - 1535 BIRCHMOUNT RD, SCARBOROUGH, ON

Return to Morneau Shepell by fax 1-877-562-9126, email dmdailyfaxes@morneaushepell.com or using myAbiliti or to RMS Canada at 647-888-6802 or scotiawc@rmscanada.ca