**Occupational Health Referral – Part A**

To be completed by the Line Manager (or Delegate)

The following employee ……………….................................… employed as a(n) ………………………………………. has been referred to you for an occupational assessment.

Mr. /Ms. ……………………………..…. has been unable to attend work since ……………………….. (Date) due to the following conditions:

…………………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………

**This form should be completed and send to Occupational Health and HR immediately (should not exceed five (5) working days since notification) once the line manager has been notified by the staff about his/ her illness in the following conditions:**

* Will be in sick leave for 7 days/ extension of sick leave
* For light duties/ extension of light duties

Line Manager Name and Signature: ...................................................

Job Title: ………………………………………………...

Date: ...............................................................

**Occupational Health Referral – Part B**

To be completed by the NA Employee

By signing above, the employee acknowledges that he/she will return the following documents to a Line Manager (or delegate)

Occupational Health Referral Form Part C completed, signed and stamped by a licensed clinician (for pregnancy a licensed obstetrician)

Sick certificate (signed and stamped by the licensed attending clinician) and any other relevant medical documentation

Employee Signature: …………………………………………...

Date: ………………………………………………….

**Occupational Health Referral – Part C**

To be completed by the attending clinician

Employee Name: ………………………………………………………………………...

1. Diagnosis: ………………………………………………………………………………………………………………

2. Is the employee able to continue his/her normal workplace duties without any physical movement limitation/ restriction? Yes □ No □

1. Is the employee required to be in sick leave? Yes □ No □

* If yes, how many days/ weeks of sick leave? ..........................................

1. Is the employee recommended to work light duties only ( limited physical activities)?

Yes □ No □

* If yes, how many days/weeks is the employee advised for light duties? ......................
* If yes, please specify the allowed activities during light duties as follows:
  + - Office work
    - Driving
    - Long standing activities
    - Others, please specify ………………………………………………………………………………………..

3. Is the illness/ injury of the employee chronic or likely to be chronic? Yes □ No □

4. If yes, is this a condition that is likely to cause the employee to have further periods of absence due to their condition? Yes □ No □

Details: ……………………………………………………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………………………………………………

5. Does the employee require any additional treatment/therapy/tests? Yes □ No □

6. If yes please explain and possible length of treatment required …………………………………………………….

.....................................................................................................................................................................

7. If the employee is pregnant please state expected date of delivery. ……………………………………………………

8. Please complete and attach a DOH/DHA/MOHAP sick leave certificate and light duty notification certificate and other relevant documents and return to National Ambulance with the following information:

a. Sick leave start date

b. Last sick leave date. Recommendation for light duties as needed.

c. Medical report

Signature: ....................................................... Name: ..................................................... Clinician’s Stamp: Date: .......................................................

**\*\*\*\*The document must be stamped and signed by the DOH/DHA/MOHAP licensed clinician\*\*\***

**Occupational Health Department at National Ambulance may make contact for clarification of details**

**Occupational Health Referral – Part D**

To be completed by the NA Chief Administrative & Medical Officer or Delegate

Occupational Health Referral Form received by:

Chief Administrative & Medical Officer /Delegate…………………………………………… Date: …………………………

With reference to the above information regarding employee ………………………………………………………..,

Diagnosis…………………………………………………………………………………………………………………………………………..

Seen by (Clinician)…………………………………………………………………………………………………………………………….

Seen at (Facility)……………………………………………………………………………………………………………………………….

Treatment/Management Plan Summary…………………………………………………………………………………………..

…………………………………………………………………………………………………………………………………………………………

The National Ambulance Chief Administrative & Medical Officer/Delegate recommends the following:

………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………

Signature: ………………………………………………………………………

Date: ……………………………………………………………………………..

**All information is to be saved on the employee’s confidential OH personnel file and where relevant, in the HR file**