AUTHORIZATION FORM FOR THE ENHANCED DISABILITY MANAGEMENT PROGRAM

This Authorization Form is to be completed upon enrollment in the EDMP

PURPOSE

Purpose of the Authorization:

The purpose of this authorization is to allow for the collection, use and disclosure of information about me that is necessary for the operation of the Enhanced Disability Management Program (EDMP), including compliance with Human Rights Legislation (the duty to accommodate), my continuation of or return to work, and to help process any disability benefits[1] I may be entitled to.

The purpose of this authorization is also to protect my right to privacy by restricting the collection, use and disclosure of my information consistent with the Confidentiality Policy that forms part of the EDMP.

This authorization will assist to:

- Determine if other medical or rehabilitation processes would be beneficial
- Develop a Case Management Plan
- Determine the type of work suitable to my medical restrictions
- Confirm the anticipated date of my safe return to work or resumption of certain duties

I understand that this authorization form is **not** an application for disability benefits (e.g. WorkSafe BC, LTD, etc.).

AUTHORIZATION TO ACCESS INFORMATION *(To be completed by Employee)*

Authorization to the DMP of_____Health Authority:

I have shared and will continue to share information about myself with my Disability Management Professional (DMP). This information relates to my illness or injury, and/or other barriers to my return to work. This information is personal and confidential, and may include medical information.

For the purpose of delivering disability management services to me, I,_____, authorize my DMP to exchange my information with the following people:

1. My EDMP union representative.

2. Other DMPs and administrative staff, working with my DMP in my employer's Disability Management Department.

I understand that my information will only be exchanged with these people where reasonably necessary for the delivery of disability management services to me in relation to my current absence from work.

I understand that these people will only use my information for the purpose of delivering disability management services to me in relation to my current absence from work.

[1] "disability benefits" are benefits provided by Work Safe BC, and Great West Life.

Return To Work Planning

For the purpose of planning and facilitating the return to work related to my current absence, I, _____, authorize as follows:

I. In the event that I have authorized my health care provider to contact my DMP to inquire about the description of my job and options for my Return-to-Work, my DMP is hereby authorized to respond. I further authorize my DMP to disclose to this health care provider, in writing, my Return-to-Work plan.

II. I authorize my DMP to share the following information with my manager:

(a) Expected date of return to work.

(b) Duration of graduated return to work (if applicable).

(c) Functional restrictions/limitations (related to illness/injury causing current absence from work) upon return to work (if applicable).

I understand that this information will only be shared with my manager where reasonably necessary to plan and facilitate the return to work related to my current absence.

I understand that my manager will only use this information for the purpose of planning and facilitating the return to work related to my current absence.

If my manager reasonably requires additional information from my DMP for the purpose of planning and facilitating my return to work, my DMP will contact me to obtain my additional authorization.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

I MAY RESCIND THIS AUTHORIZATION IN WRITING AT ANY TIME. OTHERWISE, THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL THE EARLIER OF MY RETURN TO REGULAR EMPLOYMENT OR THE CLOSURE OF MY ENHANCED DISABILITY MANAGEMENT PROGRAM FILE AT_____HEALTH AUTHORITY.

_____	_____
Print Name	Signature
( ) _____	_____
Telephone Number	Date