FIT TO WORK POLICY

DEPARTMENT: Public Works/Maintenance Department

DATE ADOPTED: March 10, 2022

RESOLUTION #: XX/2022

REVISION DATE: XX/2022

RELATED POLICIES: N/A

1. **PURPOSE**

    1. The purpose of this Policy is to ensure employees are fit to operate equipment safely and reliably for the **Rural Municipality of Lake Lenore No. 399**

    Employees are considered **Medically Fit** to continue working as long as their health does not affect their job performance. The health assessment considers physical and mental abilities, sensory acuity, level of skill, functional limitations, etc. Employees must be able to perform strenuous physical tasks of mechanical maintenance activities, and be free of disqualifying medical conditions in accordance with relevant medical fitness standards and guidelines.

2. **POLICY**

Employee Responsibilities

1. Employees are expected to report to work fit for duty and to remain fit for duty throughout their work day, and at all times in conjunction with the operation of equipment.
2. Employees are expected to be in a physical, mental, and emotional state which enables the employee to perform the essential tasks of his or her work assignment in a manner that is predictable and which does NOT threaten the safety or health of oneself, co-workers, property, or the public at large.
3. Employees are expected to disclose to their supervisor/employer if they are unfit for duty at any point. Employees are also expected to disclose any alcohol or drug use, medication use, personal problems, fatigue or any condition which may render them unfit for duty.

Medical Assessments:

1. Employees shall go through periodic general medical assessments once every 3 years.

Unfit:

1. An employee will not be permitted to work and will be sent home without pay for the duration of his or her shift when there are objective signs as assessed by the supervisor/employer that he/she may not be fit for duty. If it is determined that an employee is not fit for duty, a manager/supervisor will ensure that the employee leaves the work site and has a safe method of transportation.

Post Incident:

1. Following the occurrence of any accident or incident or near miss, the employer may conduct an investigation of any employee involved in the arising event to determine if they were fit for duty, including the potential use of a post incident medical assessment to aid in such an investigation, which may include drug and/or alcohol testing by an approved and accredited third party medical and testing authority.
2. In addition, where an employee has been deemed not fit for duty, the employer may require a medical assessment by a treating physician satisfactory to the employer prior to returning the employee to the workplace.

Violation:

1. Any violation of this policy by an employee will result in appropriate corrective action(s), which may include verbal or written warnings, suspensions without pay, or other actions up to and including the termination of the Employee's employment for cause.

Acknowledgement:

1. Employees must sign the applicable acknowledgement form attached to this policy. A copy of the signed acknowledgement form will be placed and maintained in the Employee's personnel file.

3. RESPONSIBILITIES

1. The Administrator and Public Works Foreman is responsible for ensuring compliance with this policy.
2. Council shall review the policy every three (3) years for compliance and effectiveness of the policy.

6. DOCUMENT APPROVAL

ROLE	POSITION	NAME OF APPROVER	DATE APPROVED
Author	Administrator	RM Council	03/XX/2022

7. REVISION HISTORY

EFFECTIVE DATE	DOCUMENT AUTHOR	DESCRIPTION
03/XX/2022	Kelsey Dutka	Initial Release

EMPLOYEE ACKNOWLEDGEMENT

By my signature below, I acknowledge that I have read and understand this Fit for Duty Policy and agree to abide by its terms and conditions.

I also understand that any violation of this policy will result in appropriate corrective action, which may include disciplinary action up to and including the termination of my employment for cause.

_____

Employee Name

_____ _____

Employee Signature Date

Medical Condition Report

Rural Municipality of Lake Lenore No. 399

200 Main Street, St. Brieux, SK S0K3V0
Tel: (306) 275-2066 Email: RMLL@sasktel.net

PART 1 - PATIENT INFORMATION

Last Name	First Name	Middle Initial

Date of Birth (yyyy/mm/dd)	Gender ☐ Male ☐ Female	Driver's License Number (if available)

Current Address

Unit Number	Street Number	Street Name	PO Box

City/Town/Village	Province	Postal Code

Certificate and Waiver

I certify that the information I have given in this report, to the best of my knowledge, is correct and complete. I agree to allowing my physician to forward this report directly to the RM of Lake Lenore No. 399.

Date: _____ Signature: _____

Home Phone: _____ Cell Phone: _____

PART 2 - PRACTITIONER'S INFORMATION

Practitioner's Last Name	Practitioner's First Name

Licence Number	Telephone Number

Practitioner's Address

Unit Number	Street Number	Street Name

City/Town/Village	Province	Postal Code

Relationship with Patient

I am this person's:

☐ Family/Treating Physician ☐ ER Physician ☐ Nurse Practitioner ☐ Occupational Therapist

☐ Urgent Care/Walk In Clinic Physician ☐ Other (specify) _____

How many years has this patient been in your care?

☐ 1 year or less ☐ 1 to 2 years ☐ 3 to 4 years ☐ 5 years or more

Number of times this patient has visited your office in the past 12 months: _____

Date of last office visit (yyyy/mm/dd): _____

Date you first started treating this patient's primary medical condition (yyyy/mm/dd): _____

PART 3 - MEDICAL CONDITIONS, LIMITATIONS AND TREATMENT

Medical conditions(s) and date of symptom onset:

Impairment(s):

Functional limitation(s):

Prognosis:

Condition is likely to:	☐	improve	☐	deteriorate	☐	remain the same	☐ unknown
Expected duration:	☐	less than 1 year	☐	more than 1 year			
Frequency:	☐	recurrent/episodic	☐	continuous	☐	unknown	

Medication(s), dosage and frequency	Actual/proposed start date	Actual/estimated end date	Response (e.g. efficacy, side effects, etc.) and other remarks

Type and frequency of other treatment(s)	Actual/proposed start date	Actual/estimated end date	Response (e.g. efficacy, side effects, etc.) and other remarks

Vision:

Acuities	Uncorrected	Corrected
Right	20/	20/
Left	20/	20/
Both	20/	20/

Horizontal Fields of Vision by Confrontation (circle for each eye)		
Right	Normal	Restricted
Left	Normal	Restricted

The Senses:

Hearing Loss: _____

Hearing aid: ☐ Single ☐ Bilateral

Vertigo : ☐ Controlled ☐ Uncontrolled

Menieres: ☐ Controlled ☐ Uncontrolled

Other: _____

PART 4 - PATIENT'S EMPLOYMENT SITUATION

This section gathers information to assess current and future restrictions on the patient's ability to work.

Did you recommend to your patient that they stop working?

☐ Yes, I recommended that the patient stop working as of (yyyy/mm/dd): _____

☐ No

☐ Not discussed

If you have indicated No, or that your patient has a terminal medical condition, skip the rest of this section.

From a strictly medical standpoint, do you expect your patient to return to any type of work in the future?

☐ Yes

☐ No (skip the rest of this section)

☐ Unknown (skip the rest of this section)

If yes, please indicate when you expect your patient to return to work:

☐ In 6 to 12 months ☐ In 12 to 24 months ☐ In more than 24 months ☐ Unknown

If yes, please indicate what type of work you expect your patient will be able to do:

☐ Usual work ☐ Modified work ☐ Another type of work that will require training

☐ Other: _____

PART 5 - PRACTITIONER'S DECLARATION

I confirm that, to the best of my knowledge all of the information I have provided in this report is accurate and complete.

Name	Address and telephone number (Please print or use a stamp)
Signature	
Date (yyyy/mm/dd)	