# ADMINISTRATIVE MANUAL

*Policy & Procedure*

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| **Title:** | Sick Time Approval | **Number:** | AD 10-22 |
| **Section:** | Human Resources | **Date Created:** | September 1, 2011 |
| **Sponsor:** | Dir. Of Operations/HR Coordinator | **Last Date Approved:** | Jan. 16/12; Jan 23, 2018 |
| **Author(s):** | HR Coordinator | **Next Review Date:** | January 2021 |
| **Distribution:** | All Employees | **Approval:** | Leadership Team |

## STANDARD

**DHW Long Term Care Facility Program Requirements, Final March 15/16**

11.1 The staff complement supports the achievement of the outcomes in all program areas.

**WEV Guiding Principle:**

**Trust and Accountability in and to each other**. We share what we are doing and why.

## RATIONALE

Domain of Well-Being: SECURITY: enhancing safety; certainty; assuredness; freedom from doubt, anxiety or fear.

Minimizing and managing workplace absences will support our teams to maintain an operational home that promotes employee health and safety and high standards of quality care for our residents. Obtaining all appropriate medical information as needed will assist in making effective case management decisions and formulating effective return to work plans.

## POLICY

Sick time is an indemnity benefit and not an acquired right. All sick time must be approved by the Neighbourhood Manager/Department Head. Sick time is approved when the employee's absence is for a personal illness or injury nature, the employee communicated the absence appropriately to the Neighbourhood Manager/Department Head, and if required, medical documentation was received as requested.

## PROCEDURE

If an employee is unable to report to work due to illness/injury:

1. Employee calls the Scheduling phone (902-790-0904) to inform they are not able to attend work.
2. Employee must then immediately contact their Neighbourhood Manager/Department Head to report and provide reason for their absence as well as the expected return to work date.
3. Upon notification, the Neighbourhood Manager/Department Head will notify the Scheduler to communicate the appropriate coding of the absence.
    a. Note: Sick time is paid upon approval if an employee has sufficient sick leave credits in their bank.

4. If the absence is expected to be greater than 5 consecutive shifts, the NM/DH will advise the employee the need to have an Attending Physician Report (APR) form completed and returned within 7 days. Failure to provide the APR may delay sick time approval and sick time payment.
5. When an APR is requested and received, the NM/DH will review the completed APR to determine work restrictions/limitations and determine if an accommodation is possible. The NM/DH will discuss the results with the employee and develop a return to work plan.

**Attending Physician Report (APR) form procedure:**

1. The Attending Physician's Report must be completed in its entirety and submitted to the Neighbourhood Manager/Department Head within 7 days in the following circumstances:
    a. when lost time is or expected to be greater than five (5) consecutive shifts and;
    b. every 30 days during an extended illness in excess of four (4) weeks if requested and;
    c. in exceptional circumstances, as otherwise specified by the employer – this may include, but is not limited to, situations where an employee is on the Attendance Management Program and is required to provide physician documentation before five (5) consecutive shifts of lost time and/or;
    d. when medical clearance is required to ensure an employee is safe to return to the workplace

## DEFINITIONS:

Sick time: Time away from the workplace for personal illness /injury.

## APPENDICES

Appendix A: Attending Physicians Report

## REFERENCES

- SEIU & NSNU Collective Agreements
- Attendance Management Policy
- IWK

## Appendix A

## Attending Physician's Report

**Employee:**
**Please have your treating Physician complete this form and return within 7 days to your Department Head/Neighbourhood Manager.**

**Physician:**
**Windsor Elms has an Attendance Management Program and in keeping with this program, we are committed to return our employees to their regular jobs following an occupational or non-occupational illness or injury as soon as possible. We will make every effort to accommodate work restrictions/limitations to provide a safe return to work for our staff.**

**Name of Employee: _____**

**Work Location: _____ Job Title: _____**

**Examination date: _____**

**Please give a brief description of employee's condition:**
_____
_____
_____

**Date condition began: _____**

**Prognosis: _____**

**Please list any work restrictions/limitations.**
_____
_____
_____

**Expected date to full recovery: _____**

**Physician's Signature**: _____ **Date:** _____

**Employee's Signature: _____ Date: _____**

(By signing this form I am authorizing my treating practitioner to release my work restrictions/limitations to my employer as they directly relate to my work.)