banyan
work health solutions

Referral Form - Employer Notification Form - Short Term Disability Claim

Please ensure that all fields are completed and forward to Banyan Work Health Solutions' Administrative Centre by email at **employer_services@banyanconsultants.com** or via fax toll free **1-855-734-6402**.

EMPLOYER INFORMATION:
(Name
Address Line 1
City, Province
Postal Code)

Referral Date: (d/m/y)

Date Forms Provided to Employee:

REFERRAL TYPE: ☐ **ACS Basic Review** ☐ **ACS Telephonic** ☐ **STD Claims Services** ☐ **Stay-At-Work Services** ☐ **Disability Management**

REFERRAL SOURCE INFORMATION:

Last Name: First Name: Title:

Telephone (Toll Free): Direct Line: Fax:

Email:

EMPLOYEE INFORMATION:

Last Name: First Name: Gender: ☐ Male ☐ Female

Date of Birth: (d/m/y) Preferred Language: ☐ English ☐ French

Address:

City: Province: Postal Code:

Telephone: (home) Telephone: (other)

Email:

EMPLOYMENT INFORMATION:

Employee Number: Date of Hire: (d/m/y)

Position/Title: Department:

Location/Branch: Unionized EE: ☐ Yes ☐ No If Yes, indicate type:

Type of Employment: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Casual ☐ Other ☐ On-Call

Employee's usual work schedule: ☐ Monday ☐ Thursday ☐ Tuesday ☐ Friday ☐ Wednesday ☐ Saturday/Sunday

Hours per week

Does the Employee work shifts? ☐ Yes ☐ No If Yes, indicate the number of shifts/hours per week:

Is Modified Work Available? ☐ Yes ☐ No If Yes, indicate type (modified duties/hours).

Please provide details:

500 – 21 Four Seasons Place, Etobicoke, Ontario M9B 0A5 **T** 866.226.9262 **F** 416.588.9235
www.banyanconsultants.com

Job Description attached: Yes ☐ No ☐ Physical Demands Analysis attached: Yes ☐ No ☐

If NO, please complete the following with as much detail as possible:

CRITICAL JOB DEMANDS SUMMARY

ACTIVITY		FREQUENCY OF WORKDAY					Comments
		Not Required	Rarely (1-5%)	Occasionally (6-33%)	Frequently (34-66%)	Constantly (67-100%)	
Physical Job Demands							
Manual Handling (lift/carry)	0 – 10 lbs	☐	☐	☐	☐	☐	
	11-20 lbs	☐	☐	☐	☐	☐	
	21 – 50 lbs	☐	☐	☐	☐	☐	
	50+ lbs	☐	☐	☐	☐	☐	
Climbing (stairs, ladders etc)		☐	☐	☐	☐	☐	
Bend/Crouch/Kneel		☐	☐	☐	☐	☐	
Twist/Rotate		☐	☐	☐	☐	☐	
Fine motor manipulation (i.e. grip, pinch grip, sorting)		☐	☐	☐	☐	☐	
Walking		☐	☐	☐	☐	☐	
Reaching	Above shoulder	☐	☐	☐	☐	☐	
	Below Shoulder	☐	☐	☐	☐	☐	
Other:		☐	☐	☐	☐	☐	

How much time is Employee required to maintain the following activities prior to changing positions? And total time /day (i.e. 0-2 hrs, 2-4 hrs, 4-6 hrs, 6+ hrs)?

	0-30 mins	30-60 mins	60-90 mins	90+ mins	Total time/day?	
Sitting	☐	☐	☐	☐		
Standing	☐	☐	☐	☐		
Driving	☐	☐	☐	☐		

What percentage of the Employee's day is spent on the following activities?

Talking: ______ % Writing: ______ % Computer Use: ______ %

Cognitive Job Demands	FREQUENCY OF WORKDAY					Comments
	Not Required	Rarely (1-5%)	Occasionally (6-33%)	Frequently (34-66%)	Constantly (67-100%)	
Memory/Recall	☐	☐	☐	☐	☐	
Critical Thinking/ Multitasking	☐	☐	☐	☐	☐	

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ACTIVITY	FREQUENCY OF WORKDAY					Comments
	Not Required	Rarely (1-5%)	Occasionally (6-33%)	Frequently (34-66%)	Constantly (67-100%)	
Contend with fast paced, high pressure work functions	☐	☐	☐	☐	☐	
Interact with others / Public Speaking	☐	☐	☐	☐	☐	
Supervise others (i.e. manage a team)	☐	☐	☐	☐	☐	
Deal with conflict / complaints	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	

Additional comments related to job, tasks, equipment and functions

Any workplace issues you are aware of:

ABSENCE INFORMATION:

Last Day Worked: (LDW)

First Day Absent: (FDA)

STD Start Date:

STD Maximum Duration:

Recurrent STD Claim: Yes No

Number of days RTW prior to additional leave:

Prior LTD claim related to same condition: Yes No

Date last received LTD benefits:

Other Comments:

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