The Corporation of the Town of South Bruce Peninsula

By-Law Number 58-2016

Being a By-Law to Amend By-Law Number 44-2009 Being a By-Law to Adopt the Manual Governing the Policies and Procedures for the Corporation of the Town of South Bruce Peninsula (Sick Leave)

Whereas Section 8 of the Municipal Act, 2001, c.25, as amended, provides that a municipality has the capacity, rights, powers and privileges of a natural person for the purpose of exercising its authority under this or any other Act;

And whereas Section 11 of the Municipal Act, 2001, c.25, as amended, authorizes municipalities to pass by-laws regarding the accountability and transparency of the municipality and its operations;

And whereas Section 270 (1) 5 of the Municipal Act, 2011, c.25, as amended authorizes the municipality to adopt and maintain policies with respect to the manner in which the municipality will try to ensure that it is accountable to the public for its actions, and the manner in which the municipality will try to ensure that its actions are transparent to the public;

And whereas the Council of the Corporation of the Town of South Bruce Peninsula adopted a Municipal Policy Manual and desires to amend said by-law by amending the policy regarding sick leave.

Now therefore the Council of the Corporation of the Town of South Bruce Peninsula enacts as follows:

1) That policy D.2.3 Sick Leave, shall be amended as attached hereto and shall hereby be included in the Municipal Policy Manual.

2) That all by-laws and polices inconsistent with this by-law are hereby repealed.

3) That this by-law shall come into full force and effect upon the final passing thereof.

Read a first and second time this 5th day of July, 2016.

Read a third time and finally passed this 5th day of July, 2016.
Sick Leave

Purpose
To outline the conditions under which paid sick leave will be granted to employees.

Policy
1. "Sick Leave" means the period of time you are absent from work with pay because you are sick or disabled or because of an accident for which you are not entitled to compensation under the Workplace Safety and Insurance Act.

2. No sick leave entitlement will be allowed during an employee's probationary period, provided that at the end of such period the employee's sick leave entitlement shall date back to the date of hiring.

3. All full time employees who have successfully completed a probationary period, are entitled to a maximum of ten (10) days paid sick leave per year. Sick leave shall be paid at the rate equivalent to a day's pay and shall not be carried over from year to year. A year shall be calculated from January 1\textsuperscript{st} of a calendar year to December 31\textsuperscript{st} of the same calendar year, with prorating for partial years of employment.

4. An employee shall produce proof of sickness for any absence in the form of a medical certificate (note from a physician) if so required by the Town.

5. Full time employees will be entitled to a payment equal to 75% of the remaining sick time credited to the employee in December of each year.

6. Any employee sick for more than five (5) consecutive days is required to file a medical leave certificate (note from physician) with the Town.

7. The medical leave certificate (note from a physician) must state the expected length of time the employee will be away from the office. It must also outline any limitations on work which can be performed if the leave is not a total leave from the office.
8. Employees on sick leave will surrender any Town property to the Town. This includes but is not limited to the surrender of a Town vehicle, phone or computer. Employees will not engage in work while on sick leave, other than work authorized by the medical leave certificate (note from the physician).

9. An employee on sick leave will not engage in work while on sick leave or otherwise perform work except to the extent expressly permitted in the medical leave certificate (note from the physician), and agreed to by the Town. Without limiting the generality of the previous sentence, the employee on sick leave will not participate in any meetings, will not respond to queries or emails. If an employee is away from the office because they are sick (with an appropriate medical leave), the Town respects the rights of the employee to be sick and take the appropriate time to recover. Other employees will refrain from workplace discussion and business contact with the employee who is off on sick leave.

10. Where the sick leave is not a total leave of duties, the Town will make every reasonable attempt to accommodate the employee in the working environment.

Return to Work

11. Prior to return to the office, a return to work certificate must be provided to the Town from a physician. The return to work certificate must include any phasing in of duties, as appropriate and any accommodations which will be required for the employee to return to work.

12. Where accommodations are required for return to work, the Town will work together with the employee and the physician to explore graduated return to work, modifications or other practices which address medical restrictions and functional limitations in the work environment.

13. Under no circumstances may you use sick leave to supplement your vacation period.

14. A full time employee, while on Worker’s Compensation, shall receive sick leave benefits to a maximum of twenty-five percent (25%) of his/her normal weekly remuneration, based on his/her normal work week and rate of pay at the time of the accident, to a maximum of his/her unused sick
Section: Terms and Rules of Employment

Policy Number: D.2.3

Sub-section: Attendance Policy

Effective Date: September 22, 2009

Subject: Sick Leave

Revision Dates: December 8, 2009

leave credit. During the period of compensation, the sick leave credit will be reduced by twenty-five percent (25%) of the total days for which the worker receives Worker's Compensation.

15. If you abuse your sick leave, the privilege may be revoked and you may be subject to discipline, up to and including termination.

16. The Medical Ability to Work form is attached to this policy.

Communicating with Physicians

17. Where the Town, acting reasonably, requires further information from the employee's physician because:

   a. the reason for absence is in question,

   b. the Town requires further information from the physician in relation to accommodated work which might be offered to the employee, including a statement as to what job duties the employee is capable of performing, and what limitations exist,

   c. the information provided by the physician is unclear, or the physician has not provided sufficient response in respect of information requested;

the Town is permitted to speak with the physician or obtain further written information from the physician.

18. The Town may elect to provide a job description and the medical ability to work form to the physician.

19. If required by the physician in order to communicate with the Town, the employee shall be required to promptly sign and return an appropriate form of authorization and consent to permit the release of such information to the Town.
To be completed by attending physician.

The purpose of this form is to provide the patient with the necessary information that they need to give to their employer to help the employer made decisions about accommodating the patient, providing disability leave or assessing if the patient can return to work.

Notes to Physician

1. This form is not intended for WSIB purposes. For a work-related injury or illness, the required WSIB forms must be completed.

2. This form does not replace forms related to an employee's ability to work that are required by WSIB, Third Party Insurers or Employer Funded Medical Benefit Plans.

3. Where choices are indicated below, please mark your selection.

4. Please sign and date all pages of the form and keep a copy of the form for your records.

5. Completion of this form is an uninsured medical service. There may be a fee to the patient for completion of this form.

6. When completing this form, disclose only information necessary to meet the purpose of the form. Typically it is not necessary to provide a diagnosis of treatment information.

Mail to:
Town of South Bruce Peninsula
PO Box 310, 315 George St
Wiarton Ontario
N0H 2T0

Fax to:
519-534-4862
I, the attending physician saw ________________________________
(print patient's name)
on ________________________________.
(date)

Date of injury or sickness ________________________________

This patient is medically able to work with the limitations or restrictions as of
______________________________.
(date)

Restrictions or Limitations

In my opinion, these restrictions of limitations are:

Temporary days

4 to 6 wks

less than 2 wks 6 wks to 3 mths

2 to 4 wks more than 3 mths

Permanent

Date of next appointment is (indicate n/a if not applicable) ________________

My opinion is based on the factors indicated below:

Information provided by the patient

My examination of the patient and my assessment of the findings and
health information.

I have provided this form to the patient named above.

Physician’s Signature __________________________  Date __________________________
Specific Functional Restrictions and/or Limitations

Patient’s Name ________________________________

✓ Check only those items that apply in Section A and provide details in Section B.

Definitions
Restrictions (R): This patient is advised not to perform this activity in any capacity.

Limitations (L): This patient is able to perform the activity in a reduced capacity. For example the patient is not able to perform the job with the usual speed, strength, number of repetitions or for the usual duration.

Non Limitation (NL): This patient is able to perform the activity.

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Does patient require medical aids (example, splint, brace) or personal protective equipment (example gloves, mask)?

______________ No ____________ Yes (if yes specify in Section B)

Section B

Please provide necessary details about any restrictions or limitations you have identified. Typically it is not necessary to provide a diagnosis or treatment information.

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
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I have provided this form to the patient named above

________________________________________________________________________

Physician's Signature ___________________________ Date ____________