



Teamsters Canada Rail Conference

General Committees of Adjustment
Canadian Pacific Railway

Dave Fulton
Bruce Hiller
General Chairmen
Conductors, Trainmen and Yardmen

Greg Edwards
Benoit Brunet
General Chairmen
Locomotive Engineers

R106-355.7826
500.03.7825

March 2, 2015

VIA EMAIL

Mr. Norbert Denzer
General Manager Operations Central
660 Jarvis Avenue
Winnipeg, MB R2W 3B1

Mr. Ben Serena
General Manager Operations Prairie
Building 9, 1720 - 30th Ave SE
Calgary, AB T2G 5S4

Mr. Dan Sewell
General Manager Operations BC
Building 9, 1670 Lougheed Highway
Port Coquitlam, BC V3B 5C8

Dear Sirs,

It has recently come to the Union's attention that employees' consent on Functional Abilities Forms has been expanded to include broad consent to release information to their immediate supervisors. Please accept this policy grievance filed in accordance with Article 71 of the Conductors' Collective Agreements and Article 22 of the Locomotive Engineers' Collective Agreements concerning these forms.

It is the Union's position that this consent is unnecessary, overly intrusive and in breach of our members' privacy rights. As such, the Union contends that the Company's expanded FAF/requested consent to release FAF information to supervisors constitutes an unreasonable exercise of management's rights, contrary to the Collective Agreement. As well, the Union contends that the Company's recent expanded FAF breaches members' rights including rights under PIPEDA and the Canadian Human Rights Act.

The Union's principal concern is that the expanded consent is unnecessary and intrusive. Employees' immediate supervisors are not entitled to medical information that includes diagnoses, just medical restrictions. In the Safety Critical context, CP's OHS personnel can and should attend to such information. Employees' immediate supervisors are not entitled to such fundamentally sensitive, private medical details.

At most, employees' supervisors can be entitled to know medical restrictions, if any, without reference to a diagnosis. There is no reason that this historic practice need now be expanded to provide supervisors full, intrusive access to employees' personal medical information beyond stated restrictions.

The Company has failed to demonstrate any need for this broad, expanded request for employee consent. The revised FAFs are by their very nature intrusive and inherently invasive of employee privacy interests. Moreover, the Union has serious concerns that there is a potential for information obtained through these requests to be used for an unintended purpose.

Further to this point, the Union contends that the Company's expanded FAFs unjustifiably violate our members' privacy rights, including their rights under the Personal Information Protection and Electronic Documents Act. It is totally unprecedented, overbroad and outside the scope of the relevance for employees to be required to supply their supervisors with private medical information. There is no legitimate interest to the Company in such disclosure.

The Union requests that the Company cease and desist from requiring our members to submit to a fresh medical assessment of fitness.

We appreciate your time and attention in response to the above. We hope you will appreciate that the Union is unable to accept the unnecessary and invasive disclosure of private information to Company supervisors that the Company is requesting of our members. There is no new need or issue that warrants this extraordinary request for consent.

In the interim, given the extraordinary privacy issues at stake, the Union will be directing its members to redact and initial the offending sentence in the Employee Consent portion of the FAF, pending the timely resolution of this dispute. We have attached a copy of the form and highlighted the portion on page three that we will be directing our members to redact.


Yours truly,



Dave Fulton
General Chairman - CTY West



Greg Edwards
General Chairman - LE West



Bruce Hiller
General Chairman, CTY East



Benoit Brunet
General Chairman, LE East

Encl.

cc: All Local Chairs



**CANADIAN
PACIFIC**

LETTER TO TREATING PHYSICIAN - SAFETY CRITICAL POSITIONS

Dear Treating Physician,

Canadian Pacific Railway (CP) has a Return to Work Program to assist injured or ill workers back to pre-injury/illness duties as soon as they are medically able. This program includes modified or alternate duties for employees with work limitations and/or restrictions.

The objectives of CP's RTW program are to:

- 1) Provide the support and accommodations necessary for an employee's early, safe and sustained return to their pre-injury or illness duties;
- 2) Assist employees in their recovery process;
- 3) Help employees avoid financial and personal difficulties often caused by being off work; and,
- 4) Minimize WCB claim costs.

At CP, we believe in a safe and timely return to work for our employees. Therefore, we make every effort to **accommodate any restriction/limitations an employee may have**. The tasks can range from sedentary to moderately heavy. Accommodations are customized to the individual based on his or her restrictions and/or limitations.

Included in this package is a CP Functional Abilities Form (FAF). In order for us to provide this employee with appropriate job duties within their medical restrictions, please complete Parts 4 and 5 of the FAF.

Safety Critical Positions are mandated by the Railway Safety Act and have a direct role in safe railway operations where impaired performance due to a medical condition could result in a significant incident affecting the health and safety of employees, the public, property or the environment. e.g. Locomotive Engineers, Conductors and Rail Traffic Controllers. The attached Job Demands Analysis will assist you in understanding the job requirements.

You are responsible under the Railway Safety Act to notify the Railway Company Chief Medical Officer if an employee has a medical condition that could be a threat to safe railway operations. These conditions are listed in Part 5 of the attached Functional Abilities Form (FAF) and, if your patient is currently presenting with these condition(s), you are required to report them in Part 5 of the form.

IMPORTANT – If you are reporting that the employee is totally unfit for any work at any level, including tasks that only require sitting at a desk, please complete Part 5 of the FAF and provide objective medical information why he or she cannot perform non-safety sensitive sedentary duties.

Please fax the completed form and invoice directly to CP's Occupational Health Services at 1 403 319 6803.

If you have any questions regarding our RTW Program or have issues or concerns with completing these forms, please contact us at 1-866-876-0879.

Thank you for your cooperation and assistance with your patient's return to work.

Lisa Trueman
Director, Health Services
Canadian Pacific Railway

References:

- Canadian Railway Medical Rules for Positions Critical to Safe Railway Operations (http://www.railcan.ca/publications/rule_handbook)
- CMA Driver's Guide – Determining Medical Fitness to Operate Motor Vehicles 8th Edition. (<http://www.cma.ca/driversguide>)



PART 1 – INFORMATION FOR THE TREATING PHYSICIAN TO BE READ BY TREATING PHYSICIAN

Your patient occupies a Safety Critical Position and operates or controls the movement of trains. Impaired performance due to a medical condition could result in a significant incident affecting the health and safety of employees, the public, property or the environment. As a physician assessing persons occupying these positions you are responsible under the Railway Safety Act to notify the Railway Company’s Chief Medical Officer if an employee has a medical condition that could be a threat to safe railway operations.

Canadian Pacific Railway (CP) appreciates your time in completing this form and will pay you on receipt of the attached invoice. Capabilities that must be reviewed when assessing medical fitness for railway employees in Safety Critical Positions are provided with this form.

PLEASE FOLLOW THESE STEPS:

1. Complete Part 4 (Functional Abilities) and Part 5 (Medical Report).
2. Complete Part 6 (Invoice)
3. Fax the completed form to CP’s Occupational Health Services (OHS) at (403) 319-6803.

PART 2 – EMPLOYEE INFORMATION TO BE COMPLETED BY THE SUPERVISOR

NAME OF EMPLOYEE:		EMPLOYEE NUMBER:	
POSITION/JOB NAME:		TELEPHONE #: ()	
THIS INJURY/ILLNESS IS COVERED UNDER: <input type="checkbox"/> WCB/WSIB/CSST <input type="checkbox"/> WIB <input type="checkbox"/> STD <input type="checkbox"/> LTD			
DATE OF INJURY/ILLNESS:		MARVIN INCIDENT #:	
NAME OF SUPERVISOR:			
PHONE # OF SUPERVISOR: ()		FAX #: (403) 319 – 6803	

PART 3 – EMPLOYEE CONSENT TO BE COMPLETED BY THE EMPLOYEE

I authorize the healthcare professional who has signed this form to release to CP, i.e. my supervisor, Return To Work Specialist, Occupational Health Services and, where applicable, the WCB Specialist, any functional limitations and/or restrictions information that is relevant to my return to work. I also authorize my healthcare professional to release to and discuss information concerning my present medical condition, solely, with the office of CP’s Chief Medical Officer in OHS. Furthermore, I authorize CP to release Parts 1 through 4 of this form to the appropriate union representative for the purposes of return to work planning. I also authorize OHS, CP, to release all or a portion of the medical information that is relevant to the adjudication of any benefit claim related to my present medical condition to CP’s WCB Specialist and the applicable Workers’ Compensation Board (WCB) and/or Benefit Carrier. I further authorize OHS to release relevant medical information to CP’s Supervisors where necessary to manage the employment relationship including investigating misconduct or performance issues, to assess the duty to accommodate and compliance with last chance/reinstatement/employment agreements, or to Industrial/Labour Relations and my Union Representative for the purposes of responding to grievance/arbitration or other proceedings when the information is relevant to the proceeding. Any use and disclosure of my medical information will be in accordance with legal requirements and CP Policy 1804, Privacy of Information. I also consent to receiving correspondence from OHS related to my medical condition(s) and assessments by email. This consent is valid for a period of six (6) months from the date signed below. Any medical information received by OHS will be kept in my confidential occupational health file. I understand that a copy of this consent is as valid as the original.

x _____ Employee Signature	x _____ Witness Signature	_____ Date (dd/mm/yy)
x _____ Employee Email Address		

PART 4 – FUNCTIONAL ABILITIES

TO BE COMPLETED BY THE TREATING PHYSICIAN

(Please ensure NO confidential medical information is included in this part of the form)

Patient Name: _____

Date of exam on which this report is based: _____
(dd/mm/yy)

- FIT for the USUAL DUTIES** of this position (as described on Job Demands Analysis)
- Immediately As of: _____ (dd/mm/yy)

FIT for MODIFIED / ALTERNATE DUTIES:

- Immediately As of: _____ Duration of modified/alternate duties: _____
(dd/mm/yy) (week(s)/day(s))

PLEASE COMPLETE EACH SET OF CHOICES BELOW:

WALKING (select all that apply)

- No limitations
- Limited uneven ground (loose rock, steep slopes, heavy/deep snow)
- No prolonged periods > 30 minutes
- Not more than 100 meters
- Unable to walk without assistance (cane, crutches)

CLIMBING AND BALANCE (select all that apply)

- No limitations
- Stairs only, no vertical ladders
- No working at heights (over 6 feet)

STRENGTH (lifting, carrying, pushing, pulling)

- No limitations
- Heavy Over 50 lbs occasionally
- Medium Up to 20 lbs regularly – 50 lbs occasionally
- Light Up to 10 lbs regularly – 20 lbs occasionally
- Sedentary Up to 10 lbs occasionally.

POSTURES (select all that apply)

- No limitations
- Must be able to change from sitting to standing at own discretion
- No sitting duration > 30 minutes
- No standing duration > 30 minutes

PROGNOSIS:

Complete Recovery expected: YES NO Estimated duration of restrictions: _____ week(s) Over 3 mths
 Date of next appointment/reassessment: _____ (dd/mm/yy)

UPPER LIMB (select all that apply)

- No limitations
- No above shoulder reaching: Left Right
- No firm gripping or twisting: Left Right
- No writing or keyboard use: Left Right

OPERATING MOVING EQUIPMENT (select one)

- Can operate moving equipment
- Should NOT operate moving equipment

DRIVING COMPANY VEHICLES (select all that apply)

- Can drive Company vehicles (as per license) and is meeting fitness to drive requirements for:
 - private driving commercial driving
- No driving of Company vehicles, and if so:
 - Patient is unfit to drive (private)
 - Patient is unfit to drive (commercial)
 - Recommendation made to Prov. Licensing Authority
 - License suspended by Prov. Licensing authority

SAFETY CONCERNS/COGNITIVE FUNCTION (select one)

- Normal cognitive function for alertness, concentration, attention, judgment, and memory. **(Employee may be placed in safety sensitive or critical position)**
- Some cognitive function impairment present. **(Employee must be placed in a Non-Safety Sensitive Position)**

WORK DAY DURATION (select one)

- Able to work full shift
- Graduated Work Schedule: ___hrs/day for ___week(s)

****Totally UNFIT for any work.** Date of reassessment: _____ Date of expected RTW: _____
(dd/mm/yy) (dd/mm/yy)

If you are indicating that your patient is "Totally UNFIT for any work" (including non-safety sensitive, sedentary office-type duties), you MUST also complete the Part 5 – Medical Report and provide objective medical evidence that supports Temporary Total Disability. In the absence of this information CP may offer temporary accommodation in non safety sensitive sedentary office type duties.

TREATING PHYSICIAN (please print)

Name (Print): _____ Family Physician Specialist (Specify): _____

Signature: _____ Date: _____ (dd/mm/yy)

PART 5 – MEDICAL REPORT**TO BE COMPLETED BY TREATING PHYSICIAN**

MUST COMPLETE IF YOUR PATIENT IS PRESENTING AS BEING OFF WORK DUE TO ANY OF THE FOLLOWING MEDICAL CONDITION(S):

- Significant Hearing or Vision Deficits
- Mental Disorder
- Substance Use Disorder (abuse or dependence)
- Severe Sleep Apnea
- Epileptic Seizure
- Cardiovascular Disorder
- Diabetes
- Opioid Pain Medication Use
- OR, Any other medical condition which may pose a threat to safe railway operations.
- OR, You indicate that your patient is totally unfit for any work including non-safety sensitive, sedentary, office-type duties.

Patient Name: _____ DOB (dd/mm/yy): _____

DIAGNOSIS (please be specific):

A) _____ B) _____
 C) _____ D) _____

TREATMENT – Completed and Current: (indicate dates)

Surgery _____	Date (dd/mm/yy) _____
Hospitalization _____	Date(dd/mm/yy) _____
Rehabilitation Program _____	Date(dd/mm/yy) _____
Referrals _____	Date(dd/mm/yy) _____
Investigations _____	Date(dd/mm/yy) _____
Other _____	Date (dd/mm/yy) _____

CURRENT MEDICATIONS: (name, dosage, and expected duration of use)

Name : _____	Dosage: _____	Duration: _____
Name : _____	Dosage: _____	Duration: _____
Name : _____	Dosage: _____	Duration: _____
Other(s): _____		

EFFECTS ON COGNITION: please provide your opinion on any adverse affects due to medication(s) AND/OR medical condition(s) as related to:

	NO	YES		NO	YES
Alertness	<input type="checkbox"/>	<input type="checkbox"/>	Memory	<input type="checkbox"/>	<input type="checkbox"/>
Attention	<input type="checkbox"/>	<input type="checkbox"/>	Mood	<input type="checkbox"/>	<input type="checkbox"/>
Orientation	<input type="checkbox"/>	<input type="checkbox"/>	Psychomotor functions	<input type="checkbox"/>	<input type="checkbox"/>
Judgment	<input type="checkbox"/>	<input type="checkbox"/>			

In your opinion, does your patient suffer from any medical condition that can result in sudden impairment?

NO YES, please explain: _____

In your opinion, is your patient capable of performing the duties of a Safety Critical Position?

YES NO, please explain: _____

Do you wish to discuss your patient's condition with the Company's Occupational Health Nurse?

NO YES, please specify the issue: _____

Please append copies of relevant reports from specialists, laboratory, physiotherapy, x-rays, etc.

Treating Physician Name (please print)

Name (Print): _____ Family Physician Specialist (Specify): _____

Signature _____ Date: _____
 (dd/mm/yy)

PART 6 – INVOICE (SCP FAF)

On receipt of the completed report, Canadian Pacific Railway agrees to pay to the treating physician a fee of \$100 for completion of Part 4 and Part 5. This fee is used as a guide. It is appreciated that in some circumstances a greater fee may be appropriate commensurate with the physician's time and the detail of the information provided. In such circumstances, a fee in accordance with the current provincial guidelines for uninsured services would be appropriate. No additional invoice is necessary. Please provide in the space below the person to whom the cheque should be made payable, and the address.

PLEASE WRITE LEGIBLY TO ASSIST US IN PROCESSING YOUR PAYMENT

TO BE COMPLETED FOR PAYMENT:

Name of Patient: _____

Date form completed: _____ (dd/mm/yy)

Payment made payable to: _____

TREATING PHYSICIAN NAME (**PRINT**): _____

TREATING PHYSICIAN ADDRESS: _____

TELEPHONE: () _____ FAX: () _____

FOR CANADIAN PACIFIC RAILWAY USE ONLY

AMOUNT: \$100 CANADIAN ACCOUNT:65802 INVOICE #: _____

COCODE: 1000 ORDER # 7005727 ORDER: YES

I HAVE READ AND APPROVE ACCORDING TO POLICY 6137

SIGNATURE: _____ EMPLOYEE # 964936

Fax the completed form to CP Occupational Health Services (OHS) at (403) 319-6803