acclaim
ABILITY MANAGEMENT INC.

PRINT CLEAR

Attending Physician Statement *(Medical Form)*

(Please print clearly in ink)

TO BE COMPLETED BY EMPLOYEE

Employee's Name _____ Phone No (_____)_____
(Last name first, in full) *Area Code* *Phone Number*

Address _____ _____ _____ _____
(Apt. No.) *(Street Number and Name)* *(City/Town)* *(Province)* *(Postal Code)*

Date of Birth _____ Language ☐ E ☐ F ☐ Other _____
Day Month Year

☐ I have access to a printer and am able to print all required medical forms Email Address: _____

Check ONE ☐ Left Hand dominant or ☐ Right Hand dominant or ☐ Ambidextrous

Were you hospitalized? ☐ Yes ☐ No

If YES, name of the hospital/institution _____ from _____ to _____
Day Month Year *Day Month Year*

Are you claiming or receiving any other disability, wage loss and/or retirement benefits (e.g. WSIB, CPP/QPP, auto insurance, other)? ☐ Yes ☐ No
Are you working or volunteering in any capacity? ☐ Yes ☐ No
Are you receiving wages from any source? ☐ Yes ☐ No
Are you attending any educational course, program or institution? ☐ Yes ☐ No

If yes to any of the above, please provide details of these items on a separate page and include any confirming documents, claim numbers, etc.

If an accident caused your disability, indicate date _____ WHERE and WHAT happened
Day Month Year

_____

_____

AUTHORIZATION

I, _____hereby authorize (Name of physician, hospital, clinic or any other medical or health care provider or facility) _____, to release to Acclaim Ability Management ("Acclaim") or its representatives or agents, any and all medical, employment or vocational information or records with respect to my claim for short-term disability benefits ("STD benefits", including any appeal I might institute) and for the purpose of Acclaim's evaluation, administration and management on behalf of my employer in relation to my medical absence from work from **St Clair College**, including assessing my ability to return to work and my potential need for accommodation. I further acknowledge being informed that the obligation to pay STD Benefits is solely the responsibility of my employer. I further authorize Acclaim or its representatives or agents to disclose any such information obtained in respect of my STD claim to any physician, clinic or any other medical or health care provider or facility for such purposes. I understand that my refusal or withdrawal of consent may delay the provision or result in the denial of my STD claim. I declare that the information provided in this authorization and any statements provided in any personal or telephone interview relating to my STD claim are/will be true, complete and accurate. In the event I elect to pursue legal proceedings in relation to my STD benefits claim, or in respect of any matters arising out of Acclaim's performance of the services described in this authorization, I acknowledge and agree that my sole cause of action will be against my employer and that I have no claim against Acclaim. In the event I do not return to work and I submit an application for long term disability ("LTD") benefits to **Sun Life Financial (SLF)**, I understand and authorize that all documents contained in and that are relevant to my entire STD claim file will be disclosed to **SLF** and will form part of my LTD file. I acknowledge that the services provided by Acclaim will not in any way be construed as an admission of liability by **SLF** or acceptance of a claim for the payment of LTD benefits.

This authorization shall remain valid for the duration of my claim with Acclaim and **SLF** unless revoked in writing to me. Any copy of this authorization shall be as valid as the original.

_____ _____ _____
Employee Name (Printed) *Employee Signature* *Date*

TO BE COMPLETED BY ATTENDING PHYSICIAN

The patient is responsible for any charges made for completion of this form, unless prohibited by law. Please return completed form to your patient.

ILLNESS INFORMATION

Nature of the illness or injury: _____

Date illness or injury began: _____ Date of examination by Physician: _____
Day Month Year *Day Month Year*

Date deemed totally disabled from work _____
Day Month Year

Is there a medical treatment plan currently in place? ☐ Yes ☐ No If no, why? _____

Is the employee compliant with the prescribed/recommended treatment plan? ☐ Yes ☐ No

Please send completed form to ***Acclaim Ability Management*** at 1-866-486-8663 or faxes@acclaimability.com

Employee Name: *EMPLOYER*

If employee cannot return to full duties, can the employee return to work on modified duties: ☐ Yes ☐ No Date _____
Day Month Year

If **yes**, please describe the employee's current limitations (please use the abilities section if applicable) If **NO**, please provide the medical contraindications to a modified return to work:

Expected length of time modifications will be required: _____

Is this injury or illness work related: ☐ Yes ☐ No Has a Form 8 been submitted to WSIB? ☐ Yes ☐ No

If disability is related to pregnancy, please indicate the expected date of delivery _____
Day Month Year

I see the patient every _____ (day, week, etc.) Date of most recent examination _____
Day Month Year

Has patient ever had a similar condition? Yes No **If yes, state when and describe:**

FUNCTIONAL ABILTIIES:

Walking (continuously): ☐ up to 30 min; ☐ up to 1 hour; ☐ no restriction; ☐ Other (e.g. uneven ground) _____

Standing (continuously): ☐ up to 30 min; ☐ up to 1 hour; ☐ no restriction; ☐ Other _____

Sitting (continuously): ☐ up to 30 min; ☐ up to 1 hour; ☐ no restriction; ☐ Other _____

Lifting floor to waist: ☐ up to 20 lbs; ☐ up to 30 lbs; ☐ up to 40 lbs; ☐ no restriction; ☐ Other _____

Lifting waist to shoulder: ☐ up to 20 lbs; ☐ up to 30 lbs ☐ up to 40 lbs; ☐ no restriction; ☐ Other _____

Stair climbing: ☐ unable ☐ 2 – 3 steps only; ☐ own pace ☐ assisted ☐ no restriction

Able to drive: ☐ up to 2 hours ☐ up to 4 hours; ☐ no restriction ☐ Other _____

Able to operate heavy machinery: ☐ up to 2 hours ☐ up to 4 hours ☐ no restriction ☐ Other _____

Employee is: ☐ Left handed ☐ Right handed ☐ Ambidextrous

Limited ability to used **left** hand to: ☐ hold objects; ☐ grip; ☐ type; ☐ Write

Limited ability to used **right** hand to: ☐ hold objects; ☐ grip; ☐ type; ☐ Write

Completely unable to use **left** hand to: ☐ hold objects; ☐ grip; ☐ type; ☐ write

Completely unable to use **right** hand to: ☐ hold objects; ☐ grip; ☐ type; ☐ Write

Hours per day: ☐ Full Hours ☐ Partial Hours (specify) ☐ anticipated duration _____ ☐ no restriction

COGNITIVE ABILITIES:

Deadline Pressures: ☐ limited capacity ☐ unable to perform ☐ no restriction; ☐ Other: _____

Attention ☐ limited capacity ☐ unable to perform ☐ no restriction; ☐ Other: _____

Memory ☐ limited capacity ☐ unable to perform ☐ no restriction; ☐ Other: _____

Reasoning ☐ limited capacity ☐ unable to perform ☐ no restriction; ☐ Other: _____

Problem Solving: ☐ limited capacity ☐ unable to perform ☐ no restriction; ☐ Other: _____

Other clinically assessed limitations:

If Nature of condition is Psychological/Mental Health, please advise if criteria for ICD -10- CM/ DSM 5 was evaluated:

☐ **Yes** ☐ **No**

Employee Name: *EMPLOYER*

Treatment

If hospitalized, name of the hospital/institution _____ from _____ to _____
Day Month Year *Day Month Year*

Surgery ☐ Yes ☐ No **(If yes, state surgical procedure)** _____

☐ Performed ☐ Planned Date of Surgery _____ Anesthetic ☐ Local ☐ General
Day Month Year

List medications currently prescribed and dosage _____

Therapy ☐ Yes ☐ No **If yes, indicate type (e.g. physiotherapy, psychotherapy, etc.)** _____

Frequency ☐ Daily _____ x per week ☐ Other _____

Location: ☐ Outpatient ☐ Therapist's Office ☐ Physician's Office ☐ Home

Summary of patient's response to treatment

_____

_____

Prognosis

Have you discussed a Return to Work Plan with your patient? ☐ Yes ☐ No

If no, why not? _____

If yes, please provide details about the Return to Work Plan including recommendations for modified hours and/or modified duties:

_____

_____

_____

Expected date of Return to Work Full-Time _____ Next appointment _____
Day Month Year *Day Month Year*

Additional Comments:

_____

_____

_____

_____

ATTENDING PHYSICIAN'S INFORMATION

NOTICE TO PHYSICIAN: *Any information provided by you to* ***Acclaim Ability Management*** *regarding this claim may be disclosed to the claimant and/or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the claimant or in harm to a third party.*

Physician's Name (please print): _____ Telephone: _____

Address _____ Fax _____

Signature: _____ Specialty: _____