

Attending Physician Statement (Medical Form)

Employee's Name						Phone	e No	()		
	(Last nar	me first, in full)						Area	Code	Phone Nu	mber
Address				-							
	Street Number and Name		O41 11		(Cit	ty/Town)			(Province)	(Pos	tal Code)
Date of Birth Day Month Year Lang	guage E	F	Other								
I have access to a printer and am able to	print all required	medical form	s Emai	l Address:							
Check ONE Left Hand dominant or	· Right Har	nd dominant	or	Amb	idextrous						
Were you hospitalized? Yes No	0										
If YES, name of the hospital/institution				from				to			
·				_	Day	Month	Year		Day	Month	Year
Are you claiming or receiving any other disabili		or retiremen	t benefits	(e.g. WS	IB, CPP/C	QPP, auto i	nsuran	ce, otl	her)?	Yes	No
Are you working or volunteering in any capacit Are you receiving wages from any source?	ly?									Yes Yes	No No
Are you attending any educational course, pro	gram or institution	?								Yes	No
If yes to any of the above, please provide d	letails of these ite	ms on a sep	arate pa	age and in	iclude an	y confirm	ing dod	cume	nts, claim	number	s, etc.
If an accident caused your disability, indicate d	date		V	/HERE an	d WHAT	happened					
	Day	Month	Year								
<u>I,</u>	_hereby authorize										
employment or vocational information or receinstitute) and for the purpose of Acclaim's ework from St Clair College , including assertinformed that the obligation to pay STD Benedisclose any such information obtained in respurposes. I understand that my refusal or information provided in this authorization and complete and accurate. In the event I elect Acclaim's performance of the services describ that I have no claim against Acclaim. In the Financial (SLF) , I understand and authorize will form part of my LTD file. I acknowledge acceptance of a claim for the payment of LTD	elease to Acclair cords with respect evaluation, administ ssing my ability the fits is solely the period of conditions and the fits of the	n Ability Ma to my claim stration and o return to v responsibility claim to any seent may de provided in roceedings in tation, I ackn eturn to work s contained provided by	inagemei for sho manager work and of my e physicia elay the any pers n relation owledge and I s in and th Acclaim	nt ("Accla rt-term disment on bid my pote imployer. In, clinic oprovision sonal or to my S and agree ubmit an alat are relevill not in	im") or it sability be ehalf of rential need for any other or result elephone that my application evant to reany way	ts represe enefits ("S" my employ d for acco authorize ar medica in the de interview fits claim, o sole cause n for long my entire s de consti	ntatives ID ben er in res mmoda Acclaim I or hea nial of relating or in re e of acti term di STD cla rued as	efits", elation ation. or its alth ca my S to m espect ion wi sabilit aim file an a	agents, ar including in to my me I further is represer provide in the street of the st	ny and any appedical ab acknown tatives of a certain are a laters and atters and the selection of liability.	all medic peal I migosence from the sence from the
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Employee Name:									EMF	PLOYER
If employee cannot re	eturn to full duties,	can the emp	loyee return	to work	on modified du	uties: Yes	N	o Date	e	
If yes , please describ medical contraindicat				use th	e abilities secti	on if applicable) If NO	, please	•	Month Year the
Expected length of tir	me modifications w	vill be require	d:							
Is this injury or illness	work related:	Yes	No H	as a Fo	orm 8 been sub	mitted to WSIE	3?	Yes		No
If disability is related	to pregnancy, plea	se indicate t	he expected	date of	delivery					
I see the patient ever	у		_ (day, week	, etc.)	Date of most	Day recent examin		Month		Year
Has patient ever had	a similar condition	?	Yes	No	If yes, state	when and de	scribe	Day :	Month	Year
FUNCTIONAL ABILTIII		up to	1 hour	no r	octriction:	Othor (
Walking (continuously):	up to 30 min;	·	1 hour;		estriction;	Other (e.g. unev	•	· ——		
Standing (continuously):	up to 30 min;	up to	1 hour;	no r	estriction;	Other				
Sitting (continuously):	up to 30 min;	up to	1 hour;	no r	estriction;	Other				
Lifting floor to waist:	up to 20 lbs;	up to	30 lbs;	up to	o 40 lbs;	no restriction;		Other _		
Lifting waist to shoulder	·	•	to 30 lbs	up to	o 40 lbs;	no restriction;		Other _		
· ·		steps only;	own pace		assisted	no restr				
Able to drive: up	to 2 hours	up to 4 h	•		no restriction		Other			
Able to operate heavy n	nachinery: up	to 2 hours	up to 4 h	nours	no restric	tion	Other			
Employee is: Le	eft handed	Right hand	led A	Ambidex	trous			_		
Limited ability to used le	eft hand to: ho	old objects;	grip;		type;			Write		
Limited ability to used ri	i ght hand to: ho	old objects;	grip;		type;			Write		
Completely unable to us	se left hand to:	hold objects	;	gı	rip;	type;			write	
Completely unable to us	se right hand to:	hold objects	•	gı	rip;	type;			Write	
Hours per day:	Full Hours	Partial Hours	s (specify)		anticipated dura	ation				no restriction
COGNITIVE ABILITIES	<u>3:</u>									
Deadline Pressures:	limited capacity	unable to	o perform	no	restriction;	Other:				
Attention	limited capacity	unable to	o perform	no	restriction;	Other:				
Memory	limited capacity	unable to	o perform	no	restriction;	Other:				
Reasoning	limited capacity	unable to	o perform	no	restriction;	Other:				
Problem Solving:	limited capacity	unable to	o perform	no	restriction;	Other:				
Other clinically assesse	d limitations:									
If Nature of condition Yes	on is Psychologic No	al/Mental He	ealth, please	advise	if criteria for	<u>ICD -10- CM/ [</u>	<u> </u>	was eva	<u>aluated</u> :	

Treatment												
If hospitalized, name of the hospital/institution						from		t	o			
Surgery Perform	Yes ed	No Planned	(If yes, state su Date of Surgery		· -		Day Anesthetic	Month	Year Local	Day	Month Gene	Year —— ral
List medicati	ons current	tlv prescribe	ed and dosage	Day	Month	Year						
Therapy	Yes	No	If yes, indicate	type (e.g.	physiothe	erapy, psy	ychotherapy	, etc.)				
Frequency	Daily	,	x per week		Other			•	-			
Location:	_	atient —	— · Therapist's C	Office	Physicia	n's Office	Hom	e				
Summary of	patient's re	esponse to t	reatment									
Prognosis												
Have you dis	cussed a F	Return to W	ork Plan with your	patient?	Yes	No						
If no, why n	ot?											
If yes, please	e provide d	etails about	the Return to Wor	k Plan incli	uding reco	mmendati	ons for modi	fied hou	urs and/oi	r modified	d duties	:
Expected da	te of Return	n to Work F	ull-Time	Month	Year	Next a	opointment		Day	Month	Υe	ar
Additional C	omments:		Бау	Monut	rear				Bay	WORK	70	ui
ATTENDING I				4- 41	Ability May				h - di- d			
those authoriz	ed by him/he	er to receive	tion provided by you such disclosure unle Ith of the claimant or	ss you notify	us in writing	agement r g that there	egarding this o	aim ma t likeliho	ay be disclo ood that su	osea to the ch disclos	e ciaima ure wou	nt and. Id resu
Physician's Na	ame (please	print):					_ Telephone:					
Address _							_ Fax					
Signature:					Specialt	V:						
J _						•						

EMPLOYER

Employee Name: