CLHIA ACCAP | the co-operators® A Better Place For You®

The patient is responsible for any fees related to the completion of this form.

Attending Physician's Statement - Short Term Disability Claim

Plan Member/Employee Information and Consent: TO BE COMPLETED BY THE PATIENT

Plan Member/Employee Name (Last, First, Middle Initial) ☐ Male ☐ Female	Home Phone # (+ Area Code)	Cell Phone # (+ Area Code)
Address (Street, City, Province, Postal Code)		
Employer's Name	Plan Contract #	Member Certificate #
Height	Weight	Date of Birth (dd/mm/yyyy) ____________
Last Date Worked (dd/mm/yyyy) ____________	**Date Returned to Work or Expected Return to Work Date** (dd/mm/yyyy) ____________	

I hereby authorize the release of medical and health information in my file to ____________ (Insurance Company) and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed. I understand that I am responsible for any fees related to the completion of this form.

____________ Plan Member/Employee Signature

____________ Date of Consent (dd/mm/yyyy)

Questions To Be Completed By the Physician (or Nurse Practitioner Where Applicable)

- **If your patient has returned to work or is expected to return to work within 4 weeks of the Last Date Worked, complete Page 1 only and sign the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Primary Diagnosis: ____________

____

____

Secondary and/or Complications: ____________

____

____

If Childbirth - Expected or Actual Delivery Date (dd/mm/yyyy): ____________ Vaginal ☐ C-Section ☐

Occupational Illness/injury Yes ☐ No ☐ If yes, date of event: (dd/mm/yyyy) ____________	Auto accident Yes ☐ No ☐ If yes, date of event: (dd/mm/yyyy) ____________
Date of first visit to you pertaining to this condition: (dd/mm/yyyy) ____________	First date of work absence due to condition: (dd/mm/yyyy) ____________

Hospitalization Is/was patient hospitalized ☐ or had day surgery ☐

Date of admittance (dd/mm/yyyy) ____________ Date of discharge (dd/mm/yyyy) ____________ Institution Name ____________

If surgery was performed please provide date and description of surgery

Date (dd/mm/yyyy) ____________ Description: ____________

Treatment (drug, dosage, physiotherapy, other):

____

____

Prognosis Please provide the prognosis for recovery:

____

____

CLHIA ACCAP

the co-operators
A Better Place For You®

Continuation of Attending Physician's Statement for Absences that may be Greater than 4 Weeks

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐
If yes, date: (dd/mm/yyyy) ______________________________ Treatment Provider: ______________________________________

Please describe the patient's symptoms including history, severity and frequency: ____
____
____
____
____

Frequency of Visits: ☐ Weekly ☐ Monthly ☐ Other_________________

Please attach copies of all relevant:

- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist ______________________________ Specialty___________________________ Date of Visit ______________

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations.
____
____
____
____
____

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.
____
____
____
____

Is the patient following the recommended treatment program? Yes ☐ No ☐

Do you have concerns about the patient's ability to manage his/her own affairs? Yes ☐ No ☐

Prognosis Please provide the prognosis for recovery: (if not completed on page 1)
____
____

Notice to Physician:

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Attending Physician (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone # (+ area code)	Fax # (+ area code)	
Signature	Date Signed (dd/mm/yyyy)	

Mail: Co-operators Life Insurance Company, Disability Claims Department, 1920 College Avenue, Regina SK S4P 1C4 Fax: 1-866-889-9926