Colette Shwetz

From: Jeff Robert
Sent: March-15-19 4:54 PM
To: Colette Shwetz; Tara Thompson
Cc: Wilma Carpenter
Subject: RE: Fixing of my Sick Vac Times
Attachments: Leaves Wilma C.xls

I have attached the leaves to work through Wilma's Short Term Disability. Sorry I was not able to address today.

Best regards,
Jeff Robert
HR Generalist

Nishnawbe-Aski Legal Services Corporation
Unit 100, 1805 Arthur St E, Thunder Bay, ON, P7E 2R6
Tel: (807) 622-1413
Toll Free: 1-800-465-5581
Fax: (807) 622-3024
Email: jrobert@nanlegal.on.ca

From: Wilma Carpenter <wcarpenter@nanlegal.on.ca>
Sent: March-15-19 11:48 AM
To: Jeff Robert <jrobert@nanlegal.on.ca>
Cc: Michelle Donio-King <mdonioking@nanlegal.on.ca>
Subject: Fixing of my Sick Vac Times

I still awaiting on my sick days that I was suppose to be getting back - not sure of on the amount of days though, this was for my Short Term Disability.

Back

Also on the Jan 19 - Feb 1 pay period - it states 4 Vacation days used - it in fact suppose to be 2 Vacation Days and 2 Sick days. This was to be straighten out.

Jan 19 - 1

On the Feb 2 - 15 - no change to my Vacation as being adjusted

On the Feb 16 - Mar 1 - still no change

So I would like to know what exact days of Vacation Days , Sick Days and Overtime hours do I have left.

Thanks

Wilma Carpenter

Victim Witness Liaison - West

P.O. Box 546

03/15/19 4 **Attendar** 1

Wilma Carpenter 11/01/17 - 03/15/19

nce Types: SL Sick Leave
Vac Vacation

Date	Absence	Time
11/06/17	SL	7:00
03/01/18	Vac	7:00
03/02/18	Vac	7:00
03/05/18	Vac	1:15
03/26/18	Vac	7:00
03/27/18	Vac	7:00
03/28/18	Vac	7:00
03/29/18	Vac	7:00
04/09/18	SL	2:00
06/07/18	SL	1:30
06/19/18	Vac	7:00
06/20/18	Vac	7:00
07/23/18	SL	0:30
08/29/18	Vac	7:00
08/30/18	Vac	7:00
08/31/18	Vac	7:00
09/12/18	SL	3:30
09/18/18	SL	1:00
10/09/18	Vac	7:00
10/23/18	SL	7:00
10/24/18	SL	7:00
10/25/18	SL	3:30
10/26/18	SL	7:00
10/29/18	SL	7:00
10/30/18	SL	7:00
10/31/18	SL	7:00
11/01/18	SL	7:00
11/02/18	SL	7:00
11/03/18	SL	0:00
11/04/18	SL	0:00
11/05/18	SL	7:00
11/06/18	SL	7:00
11/07/18	SL	7:00
11/08/18	SL	7:00
11/09/18	SL	7:00
11/15/18	SL	1:00
11/16/18	SL	1:00
01/27/19	Vac	0:00
01/28/19	Vac	7:00
01/29/19	Vac	7:00
01/31/19	Vac	7:00
02/01/19	Vac	7:00
02/05/19	Vac	7:00
03/11/19	Vac	7:00

Last day worked Oct 22/18

Donna - Primo

Manulife

Group Benefits Sponsor Statement
Group Disability Claim

- Please ensure to answer all questions.
- Please attach details on any additional information that you believe should be considered in assessing this plan member's claim.
- This notification must be sent to Manulife without delay.

Please send this form to:
Manulife Group Benefits
Attention: Disability Claims
PO BOX 800, STN WATERLOO, Waterloo ON N2J 4C2
Tel: 1-877-481-9169 or (519) 747-7000 Fax: 1-866-677-4215 or (519) 579-3680
E-mail: group_disability_claims@manulife.com

1 Benefit application

Please select the benefit type for which the plan member is applying:

(●) Short-term disability ( ) Long-term disability ( ) Waiver of premiums ( ) Critical illness ( ) Dismemberment

2 Plan sponsor information

Plan contract number 0110020 Plan sponsor name Nishnawbe-Aski Legal Services

Street address (number, street, suite) 1805 Arthur St E, Unite 100

City Thunder Bay Province ON Postal code P7E 2R6

Plan sponsor contact name Jeff Robert Job title HR Generalist

Phone number (807) 622-1413 Fax (807) 622-3024 E-mail jrobert@nanlegal.on.ca

Health centre contact and return work contact
If different from above, please indicate the person in the health centre involved in disability absences.

Name _____ Job title _____

Phone number ( ) E-mail _____

If different from above, please indicate the person we should contact to facilitate a return to work once this employee's abilities and limitations are known.

Name _____ Job title _____

Phone number ( ) E-mail _____

3 Plan member identification and work information

Full name (first, middle initial, last) Wilma A. Carpenter

Date of birth (dd/mmm/yyyy) 06/Jun/1962

Certificate number 000000047 Primary phone number (807) 738-2867 Alternate phone number ( )

Class A Division _____ Job title Victim Witness Liaison

Permanent employee (●) Yes ( ) No Date of hire (dd/mmm/yyyy) 15/May/2017

Date for which the plan member was first covered under this plan. Date (dd/mmm/yyyy) 01/Feb/2018

Has there been any interruption in the plan member's coverage? ( ) Yes (●) No

Please indicate the **HOURS** of work in a normal week.

Is this shift work? (●) Yes ( ) No

If *yes*, please indicate the work schedule or attach a copy of the work schedule.

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Hours of work each day	7	7	7	7	7		

Provide details if plan member's shift schedule is varied or rotational: _____

Is the member required to work night shift? ( ) Yes (●) No

Plan member's gross salary as of the last day of work $ 844.14 (●) Per week ( ) Per month

Was the plan member: (●) Salaried ( ) Hourly

What was the last date at work? Date (dd/mmm/yyyy) 23/Oct/2018

3 Plan member identification and work information (continued)

Was this a full day/shift? ○ Yes ◉ No

If *no*, how many hours were worked? 0 Is the absence work related? ○ Yes ◉ No

What was the plan member's first missed day of work? Date (dd/mmm/yyyy) 23/Oct/2018

Has the plan member returned to work? ◉ Yes ○ No If *yes*, when? Date (dd/mmm/yyyy) 13/Nov/2018

Did the plan member return to: ○ Regular duties ◉ Modified duties

Tax Information - Please complete only if the benefit is taxable

TD1 code _____ TP1 code _____ Plan member's province of residence for income tax purposes _____

Is employment income tax exempt according to terms of Indian Act and Income Tax Act? ◉ Yes ○ No If *yes*, please provide copy of TD1-IN.

Please indicate if any of the following have been paid (or are payable) since date plan member last worked

	Amount	**Dates (dd/mmm/yyyy)**
Salary continuance	_____	From _____ To _____
Vacation	_____	From _____ To _____
Sick Leave	_____	From _____ To _____
Severance	_____	From _____ To _____
Employment Insurance benefits	_____	From _____ To _____
Other * _____ (please indicate the source)	_____	From _____ To _____

*E.g. Short-term disability benefits, commissions or bonuses, retirement pension. If more space is needed, please use a separate sheet of paper.

4 Life coverage

To be completed for self-administered groups applying for waiver of premium or please provide a copy of the Enrolment Application.

Group Life Benefit

Plan contract number _____ Division _____ Effective date of coverage (dd/mmm/yyyy) _____

Annual salary $_____ Date of last increase (dd/mmm/yyyy) _____

Life coverage when last actively at work ○ Terminated ○ Active ○ Suspended

Amount of Life coverage

○ Basic $_____ ○ Spousal $_____ ○ Dependent Children $_____

○ Optional $_____ ○ Optional Spousal $_____ ○ Other _____ (specify) $_____

Group Accidental Death and Dismemberment Benefit (AD & D)

Plan contract number _____ Division _____ Effective date of coverage (dd/mmm/yyyy) _____

Amount of AD & D coverage

○ Basic $_____ ○ Optional $_____ ○ Spousal $_____ ○ Optional Spousal $_____

Group Survivor Income Benefit

Plan contract number _____ Division _____ Effective date of coverage (dd/mmm/yyyy) _____

Monthly survivor benefit amount $_____ Type of coverage ○ Spousal ○ Spousal and children ○ Other (specify) _____

Critical Illness Benefit

Plan contract number _____ Division _____ Effective date of coverage (dd/mmm/yyyy) _____

Amount of Critical Illness Benefit

○ Plan member basic $_____ ○ Plan member optional $_____ ○ Spousal $_____ ○ Child $_____

5 Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Name Selly Robert Title HR Generalist

Signature _____ Date (dd/mmm/yyyy) ~~23~~ 23/11/2018

Please ensure section 6 is completed by the plan member's supervisor.

6 Occupational information

This section may be separated from the rest of the form if necessary. Please attach a physical demands analysis if available.

Completed by:

Name and title: Jeff Robert, HR Generalist

Date completed (dd/mmm/yyyy): 23/Nov/2018

What was the plan member's occupation immediately prior to the plan member stopping work? Victim Witness Liaison

Were the plan member's duties and/or hours modified from their regular occupation? ○ Yes ◉ No If so, when? (dd/mmm/yyyy) _____

Please describe this plan member's regular duties (or attach a copy of the company's job description) as well as any modifications, if any.

Meet in variable locations with victims and witnesses of crime to help through the court process.

7 Occupational demands

The following physical demands analysis of the plan member's occupation is to be completed by his/her supervisor. In the appropriate column, please specify the frequency for which the following activities are regularly performed:

PHYSICAL ACTIVITIES

Activity	N/A	INFREQUENT 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
Walking	○	○	◉	○
Sitting	○	○	◉	○
Standing	○	○	◉	○
Driving / Operating machinery	○	○	◉	○
Climbing up and down the stairs	○	◉	○	○

Does the employee's occupation require repetitive movements? ◉ Yes ○ No

Lifting	N/A	INFREQUENT 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
0-10 lb.	○	◉	○	○
11-20 lb.	○	◉	○	○
21-50 lb.	◉	○	○	○
51-100 lb.	◉	○	○	○
100+ lb.	◉	○	○	○

Pushing/ Pulling	N/A	INFREQUENT 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
0-10 lb.	○	◉	○	○
11-20 lb.	○	◉	○	○
21-50 lb.	◉	○	○	○
51-100 lb.	◉	○	○	○
100+ lb.	◉	○	○	○

Does the plan member use a lifting device? ○ Yes ◉ No

COGNITIVE ACTIVITIES

Activity	Definition	N/A	INFREQUENT 0-33% of the workday	FREQUENT 34-66% of the workday	CONSTANT 67-100% of the workday
Understanding and memory	Understanding and remembering instructions	○	○	○	◉
Sustained concentration	Maintaining attention and concentration for extended periods	○	○	○	◉
Social interaction	Interaction with co-workers and/or the general public	○	○	○	◉
Adaptation and multitasking	Response to frequent changes, juggle tasks and prioritizes	○	○	○	◉
Meeting deadlines	The work involves time pressure and deadlines	○	○	○	◉
Responsibility and accountability	Errors in judgement or attention can have significant consequences	○	○	○	◉

8 Declaration

I certify that the information in this form is true and complete, to the best of my knowledge.

Name: Jeff Robert Title: HR Generalist

Signature: _____ Date (dd/mmm/yyyy): 23/11/2018

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

Canada Revenue Agency | Agence du revenu du Canada

Protected B when completed

Determination of Exemption of an Indian's Employment Income

To make sure correct information is entered, we suggest that this form be filled out by the employer, in the presence of the employee.

As an employer, you can use this form to help determine if an employee's employment income is exempt from income tax. The term "employee" on this form refers only to an employee who is registered as an Indian with Indigenous and Northern Affairs Canada, according to the terms of the *Indian Act*, or who is entitled to be so registered.

Read the instructions on the next page for more information on how to fill out this form.

Employee identification

Last name (please print)	Usual first name and initial(s)	Social insurance number
Carpenter	Wilma A	465 277 432

Residential address including postal code P.O. Box 1598
131 King St, Sioux Lookout, ON P8T 1C3

Is the employee's residence located on a reserve? Yes ☐ No ☒

Indian status

Is the employee registered or entitled to be registered as an Indian under the *Indian Act*? Yes ☒ No ☐

If yes, was the employee entitled to be registered:

- ☒ prior to 2011?
- ☐ under Bill C-3 (also known as the *Gender Equity in Indian Registration Act*)? Only income earned on or after January 31, 2011, may be exempt from tax.
- ☐ because of the creation of the Qalipu Mi'kmaq First Nation Band? Only income earned on or after September 22, 2011, may be exempt from tax.

Type of exemption *1

The employee performs employment duties:

☐ 1. entirely on a reserve ☐ 2. entirely off a reserve ☒ 3. partially on and partially off a reserve

If you chose 3, indicate the percentage of the employment duties the employee performs on a reserve: _____ %

All of the employee's employment income is exempt from income tax if any one of the following situations applies. Check the appropriate box.

- ☐ the employee performs at **least 90%** *2 of the employment duties on a reserve (guideline 1);
- ☐ the employee and the employer reside on a reserve (guideline 2);
- ☐ the employee performs **more than 50%** of the employment duties on a reserve, and the employee or the employer resides on a reserve (guideline 3); or
- ☒ the employee's employment duties are connected to the employer's non-commercial activities carried on exclusively for the benefit of Indians who, for the most part, reside on reserves and the employer resides on a reserve; **and** the employer is:
  - an Indian band that has a reserve or a tribal council representing one or more Indian bands that have reserves; **or**
  - an Indian organization controlled by one or more such bands or tribal councils and is dedicated exclusively to the social, cultural, educational, or economic development of Indians who, for the most part, reside on reserves (guideline 4).

*1 The type of exemption is based on the *Indian Act Exemption for Employment Income Guidelines*. For a full description of the Guidelines including examples of exempt income and term definitions, go to cra.gc.ca/brgnls/gdlns-eng.html.

*2 **Proration rule may apply:** When less than 90% of the duties of an employment are performed on a reserve and the employment income is not exempted by another guideline, the exemption is to be prorated. The exemption will apply to the portion of the income related to the duties performed on the reserve.

Employee certification

I certify that the information given on this form is correct and complete.

Signature Z Carpenter Date May 29/17

Personal information is collected under the *Income Tax Act* to administer tax, benefits, and related programs. It may also be used for any purpose related to the administration or enforcement of the Act such as audit, compliance and the payment of debts owed to the Crown. It may be shared or verified with other federal, provincial/territorial government institutions to the extent authorized by law. Failure to provide this information may result in interest payable, penalties or other actions. Under the *Privacy Act*, individuals have the right to access their personal information and request correction if there are errors or omissions. Refer to Info Source at cra.gc.ca/gncy/tp/nfsrc/nfsrc-eng.html, Personal Information Bank CRA PPU 047.

(Vous pouvez obtenir ce formulaire en français à arc.gc.ca/formulaires ou en composant le **1-800-959-7775.**)

Canada

Manulife

Group Benefits Plan Member Statement
Group Disability Claim Form

Please send completed form to:
Manulife Group Benefits
Attention: Disability Claims
PO BOX 800 STN WATERLOO, Waterloo ON N2J 4C2
Tel: 1-877-481-9169 or (519) 747-7000
Fax: 1-866-677-4215 or (519) 579-3680
Email: group_disability_claims@manulife.com

Please ensure to answer all questions. Additional statements may be submitted if there is insufficient space on this form. Refer to your booklet for information about your plan.

1 Benefit application Please select the benefit type for which the plan member is applying.

(X) Short term disability ( ) Long term disability ( ) Waiver of premiums ( ) Critical illness ( ) Dismemberment

2 Plan member information You can obtain your plan contract number, division number and your plan member certificate number from your benefit card.

Plan sponsor name Nishnawbe-Aski Legal Services Corporation

Plan contract number 0110020 Division _____ Certificate number 00000047

Full name (first, middle initial, last) Wilma A. Carpenter

SIN (if benefit is taxable) _____ Date of birth (dd/mmm/yyyy) 06/Jun/1962 Sex F

Height 5'8" Weight 192 lbs Number of dependents and ages 1 (20yrs) Language preference: (X) English ( ) French

Street address (number, street, apt) 131 King St, Box 1598

City Sioux Lookout Province Ontario Postal code P8T 1C3

Primary phone number (807) 738-2867 Alternate phone number ( )

Work phone number (807) 737-1796 Ext. _____

By providing my personal email address, I am authorizing Manulife to communicate with me about my file by email. I acknowledge that correspondence by email may contain personal information including, but not limited to medical, employment and financial information. Manulife cannot guarantee integrity and security of information transmitted by email. I also acknowledge that Manulife will not be responsible or liable for any loss or damages I may incur if I communicate/exchange confidential or other personal information with Manulife by email.

Email address wilma.carpenter@live.ca

3 Direct deposit authorization If your plan sponsor allows direct deposit, please complete this section to receiving benefits by direct deposit in the event that your claim is approved.

( ) If depositing into a savings account, please complete the required information, sign the authorization and provide a copy of a direct deposit form or a bank verification statement

(X) If depositing into a chequing account, please sign the authorization, and attach a copy of a void cheque

Name of financial institution Bank of Montreal

Address of financial institution (number, street, suite) 61 Front St Box 639

City Sioux Lookout Province Ontario Postal code P8T 1B1

Type of account: (X) Chequing ( ) Savings

Branch or transit number (5 digits) 24037 Institution number (3 digits) 001

Bank account number (maximum 12 digits) 000 3036-989

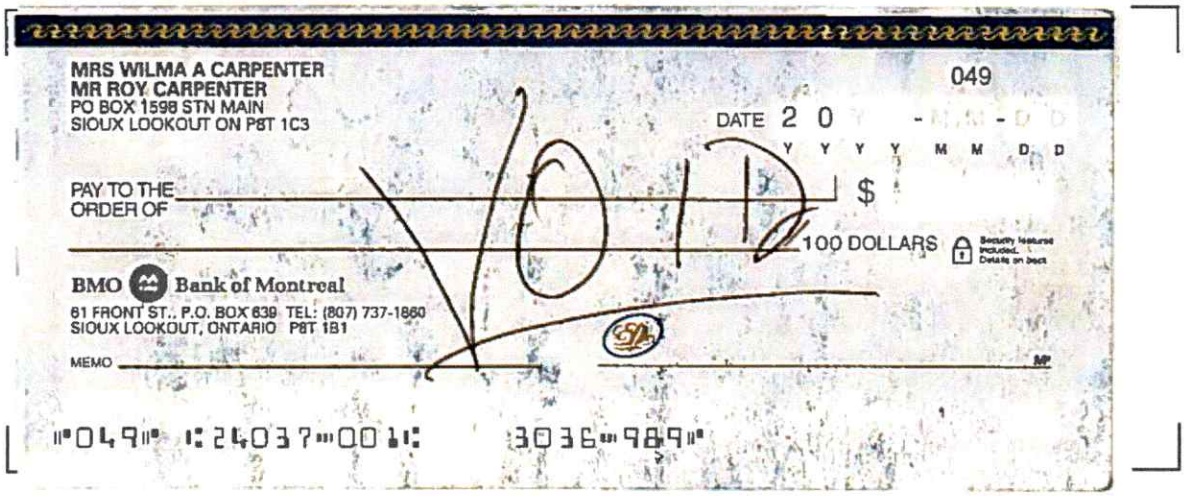
Continued on the next page.

3 Direct deposit authorization (continued)

I hereby authorize Manulife to deposit, until further notice, payment due to me from the above policy, into my bank account. **I agree** that Manulife will have no further liability with respect to any payments made in accordance with this authorization, and may at any time discontinue payment as requested herein and require my personal endorsement. **I, for myself, my heirs, my executors, administrators, and assigns do hereby consent and agree** that any sums of money so paid to the bank after my death shall be refunded to Manulife for distribution to the person or persons, if any, entitled thereto under the terms of the policy. For Group Life and Health policies, **I authorize** the use of my Social Insurance Number (SIN) when applicable for the purposes of my request for Direct Bank Deposit. The above request and authorization apply to any other account in this financial institution or any other financial institution subsequently named by me.

Plan member signature Z Carpenter Date (dd/mmm/yyyy) 19-11-2018

Plan member name (please print) Wilma Carpenter



4 Injury information

Occupation Victim Witness Liaison Original date of hire (dd/mmm/yyyy) 15-May-2017

Is your injury/illness work related? ○ Yes ☒ No

If no, was the reason you stopped working due to: ○ Illness ☒ Injury away from work ○ Motor vehicle accident (Please provide a copy of the police report)

If you have suffered an injury, please describe how, when and where the injury occurred.

Injury occurred Oct 22, 2018 burnt my left foot with hot cooking oil. I spilled hot oil on my left foot while taking frying pan outside, as I was putting down on the ground, my hand slipped and the oil splattered on my left foot.

Is there any legal action? ○ Yes ☒ No If yes, please provide the lawyer's contact information.

Lawyer's name _____ Phone number ( ) _____ Ext. _____

Lawyer's address (number, street, suite) _____

City _____ Province _____ Postal code _____

5 Work information

What was the last date at work? (dd/mmm/yyyy) 22-Oct-2018

Was this a full day/shift? ☒ Yes ○ No If no, how many hours were worked on your last day? _____

Have you performed any other paid or volunteer work since that date? ○ Yes ☒ No

If yes, please describe. Dates (dd/mmm/yyyy)

last day of work From 22-Oct 2018. To _____

off work. From 23-Oct 2018 To 24-Oct-2018

tried to work Oct 25/2018 half day only From _____ To _____

off work From 25-Oct 2018 To 26-Oct 2018

off work (pin) 29-Oct 2018 to 09-Nov 201

worked Nov 13-16/18 full days

off work Nov 19-2018 to Nov 30, 2018

8 Other income information

If you have applied for, or are receiving any income from any of the following sources, please complete the following and submit a copy of your notice of acceptance, if applicable.

Source	Have you applied? Yes	Have you applied? No	Are you receiving payment? Yes	Are you receiving payment? No	Date benefit commenced? (dd/mmm/yyyy)	Amount ($)	Please describe or provide claim number, contact name and telephone number
Canada/Quebec Pension Plan							
○ Disability	○	X	○	X			
○ Retirement							
Worker's compensation*	○	X	○	X			
Employment insurance	○	X	○	X			
Auto insurance	○	X	○	X			
Other insurance	○	X	○	X			
Income from any other source	○	X	○	X			

*Includes any type of benefit for work related illness or injury including Workers' Compensation Board (WCB), Workplace Safety and Insurance Board (WSIB) and Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST).

9 When to contact Manulife

NOTIFY MANULIFE PROMPTLY IN THE FOLLOWING CASES

I acknowledge I must notify Manulife immediately if:

a) my medical condition improves, even though I have not yet returned to work
b) I start work either as an employee or a self-employed person
c) I apply for benefits under any workers' compensation law or plan as defined in section 8
d) I apply for benefits under Canada/Quebec Pension Plan
e) I receive any benefits or income from any other source
f) I am admitted or discharged from hospital
g) I receive any other benefits/income related to my disability
h) I am leaving the country or traveling
i) I am or will be returning to school

Plan member signature W Carpenter Date (dd/mmm/yyyy) 19-Nov-2018

10 Agreement, authorization and acknowledgement

Please sign this authorization and send to Manulife using one of the following methods.

Via fax: (519) 579-3680 or 1-866-677-4215
Via email: group_disability_claims@manulife.com
Via regular mail to: **Manulife Group Benefits**
Attention: Disability Claims, PO BOX 800 STN WATERLOO, Waterloo ON N2J 4C2

I confirm:

- that the information in this form, and any further verbal or written statement provided by me in the future, is true and complete to the best of my knowledge.
- that my claim(s) and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.
- I am required to refund any monies that I may owe to Manulife in accordance with the provisions of the group benefits plan with Manulife, and I authorize Manulife to deduct monies from my group benefits.
- that a photocopy or electronic version of this authorization shall be as valid as the original.

I authorize:

- Manulife and/or its service providers, its reinsurers and its service providers, and any person or organization who has personal information about me, including an administrator of government benefits or other benefits programs to collect, use, maintain and disclose my personal information for the purposes of group benefits plan administration and audits as well as the assessment, investigation and management of my claim(s), including independent medical assessments.
- Manulife to use my SIN for the purposes of tax reporting and identification and administration, if my SIN is used as my plan member certificate number.
- Manulife to release information to my Employer/Plan Sponsor or a Third Party Administrator of my Plan Sponsor for plan administration purposes.

I acknowledge:

- that my medical information will not be provided to my Employer/Plan Sponsor or a Third Party Administrator of my Plan Sponsor unless my consent is explicitly obtained.
- that more specific details regarding how and why Manulife collects, uses, maintains, and discloses my personal information can be found in Manulife's Privacy Policy, available at **https://www.manulife.ca/corporate/privacy-policy.html** or from my Plan Sponsor.
- that any personal information provided to or collected by Manulife in accordance with this authorization will be kept in a group life, health, or disability benefits file. Access to or disclosure of my personal information will be limited to Manulife employees, representatives, reinsurers, and service providers in the performance of their jobs; persons to whom I have granted access or authorized disclosure; and persons authorized by law.
- I have the right to request access to the personal information in my file, and, where appropriate, to have any inaccurate information corrected.
- I may revoke my authorizations in this section at any time by sending a written instruction to Manulife and I understand that this may impact the administration of my claim and any benefit payment.

Plan member signature W Carpenter Date (dd/mmm/yyyy) 19-Nov-2018

Plan member name (please print) Wilma A. Carpenter

Please note: The information in this statement will be kept in a group life, health, and/or disability case file with Manulife and might be accessible by the employee or third parties to whom access has been granted or those authorized by law.

6 Illness information

When were you first treated by a physician for the current absence? (dd/mmm/yyyy) Oct 22, 2018

Please describe your symptoms and their frequency.
Foot to be cleaned daily/on meds
my left foot got infected. Seen doctor Oct 22 at Emerge, no meds given. Then Oct 23 recd prescription. Seen Dr O'Driscoll at Hugh Allen Clinic to see how foot was doing. Oct 30 went to emerge again on Oct 31 given prescriptions but on IV. Been going to Day Meds from Oct 31 - Nov 19 and to continue until healed

What work duties do your symptoms prevent you from performing?
• Advised to stay off my foot, I do lots of walking and do alleviate my foot as best as possible

Have you ever had the same or similar illness or injury? ○ Yes ⊗ No

Did it result in an absence from work? ○ Yes ○ No If yes, please describe, include dates and treatment provided.

Do you have an expected return to work date? ○ Yes ✗ No If yes, please provide the date (dd/mmm/yyyy) _____

7 Health care professional information

Please list all of the health care professionals you have seen for this illness or injury and any health care professionals you plan to see in the near future about this illness or injury. Please include family physicians, nurse practitioners, specialists, physiotherapists, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name dr on-call Specialty doctor

Address of health care professional (number, street, suite) 1 Memorial Win Way

City Sioux Lookout Province Ont Postal code P8T 1B4

Phone number (807) 737-3030 Fax number ( )

Consulted: From: (dd/mmm/yyyy) 22-10-2018 To: (dd/mmm/yyyy) 22-10-2018

Date of next visit (dd/mmm/yyyy) _____ Frequency of visits _____

Name Dr. Goldstein Specialty doctor

Address of health care professional (number, street, suite) 1 Memorial Win Way Box 909

City Sioux Lookout Province Ontario Postal code P8T 1B4

Phone number (807) 737-3030 Fax number ( )

Consulted: From: (dd/mmm/yyyy) 23-10-2018 To: (dd/mmm/yyyy) 23-10-2018

Date of next visit (dd/mmm/yyyy) _____ Frequency of visits _____

Name Dr O'Driscoll Specialty doctor

Address of health care professional (number, street, suite) 79 5th Avenue. Box 489

City Sioux Lookout Province Ontario Postal code P8T 1A8

Phone number (807) 737-3803 Fax number ( )

Consulted: From: (dd/mmm/yyyy) 25-10-2018 To: (dd/mmm/yyyy) 25-10-2018

Date of next visit (dd/mmm/yyyy) _____ Frequency of visits _____

continued on next page

7 Health care professional information Please list all of the health care professionals you have seen for this illness or injury and any health care professionals you plan to see in the near future about this illness or injury. Please include family physicians, nurse practitioners, specialists, physiotherapists, psychologists, etc. If the space provided below is insufficient, please attach a separate page and list the additional health care professionals.

Name Dr. Gretchen Finn Specialty doctor (emerg)

Address of health care professional (number, street, suite) 1 Meno Ya Win Way

City Sioux Lookout Province Ont Postal code P8T 1B4

Phone number (807) 737-3030 Fax number ( )

Consulted: From: (dd/mmm/yyyy) 30-10-2018 To: (dd/mmm/yyyy) 30-10-2018

Date of next visit (dd/mmm/yyyy) _____ Frequency of visits _____

Name Dr. Alice Gwyn Specialty doctor (emerg)

Address of health care professional (number, street, suite) 1 Meno Ya Win Way

City Sioux Lookout Province Ont Postal code P8T 1B4

Phone number (807) 737-3030 Fax number ( )

Consulted: From: (dd/mmm/yyyy) 31-10-2018 To: (dd/mmm/yyyy) 31-10-2018

Date of next visit (dd/mmm/yyyy) _____ Frequency of visits _____

Name Dr. Aaron Rothstein Specialty doctor

Address of health care professional (number, street, suite) 1 Meno Ya Win Way

City Sioux Lookout Province Ont Postal code P8T 1B4

Phone number (807) 737-3030 Fax number ( )

Consulted: From: (dd/mmm/yyyy) 17-11-2018 To: (dd/mmm/yyyy) 17-11-2018

Date of next visit (dd/mmm/yyyy) 19-11-2018 Frequency of visits as needed

Seen Dr. Murdoch - 1 Meno Ya Win Way P8T 1B4
Sioux Lookout ON
(807) 737-3030

Consulted 19-11-2018 update on progress
Date of next 21-11-2018 as needed

TC

NEXT PAGE IS A LIST OF VISITS TO HOSPITAL

Carpenter,Wilma Ann Med Rec Num: SL00004251
56/F 06/06/1962

EMR Num: GEP0476854

Patient Data | Visits | Critical Care Indicators | Amendments

Date	Type	Account Num	Location	Provider	Dis Date	Conf
19/11/18	RCR	SA072208/18	SL MED DC	KIRLM		
18/11/18	ER	SA072257/18	SL ERD	THMIM	18/11/18	
17/11/18	ER	SA072173/18	SL ERD	ROTHA	17/11/18	
16/11/18	RCR	SA066443/18	SL MED DC	GILEC		
15/11/18	Revisit	SA066443/18	SL MED DC	GILEC		
14/11/18	Revisit	SA066443/18	SL MED DC	GILEC		
13/11/18	Revisit	SA066443/18	SL MED DC	GILEC		
09/11/18	Revisit	SA066443/18	SL MED DC	COUPR		
07/11/18	Revisit	SA066443/18	SL MED DC	COUPR		
06/11/18	Revisit	SA066443/18	SL MED DC	COUPR		
05/11/18	Revisit	SA066443/18	SL MED DC	COUPR		
02/11/18	Revisit	SA066443/18	SL MED DC	GWYNA		
01/11/18	Revisit	SA066443/18	SL MED DC	GWYNA		
01/11/18	Revisit	SA066443/18	SL MED DC	GWYNA		
31/10/18	Revisit	SA066443/18	SL MED DC	GWYNA		
31/10/18	Initial	SA066443/18	SL MED DC	GWYNA		
11/11/18	ER	SA070139/18	SL ERD	DOOLJ	11/11/18	
04/11/18	ER	SA067950/18	SL ERD	MURDA	04/11/18	
03/11/18	ER	SA067801/18	SL ERD	MURDA	03/11/18	
01/11/18	ER	SA067270/18	SL ERD	SPRAC	01/11/18	
31/10/18	ER	SA066844/18	SL ERD	HANCL	31/10/18	
31/10/18	ER	SA066444/18	SL ERD	GERBL	31/10/18	
30/10/18	ER	SA066372/18	SL ERD	LAASL	30/10/18	
22/10/18	ER	SA063391/18	SL ERD	GOLDB	22/10/18	

Date	19/11/18	
Type	RCR	
Account Number	SA072208/18	
Facility		
Location	SL MED DC	
Provider Name	KIRLM	MICHAEL KIRLEW MD
Discharge Date		
Discharge Disposition		
Pre/Sch Reservation Date	19/11/18	
Reason for Visit	MD FOLLOW UP	

Manulife

CLHIA ACCAP

Group Benefits
Attending Physician Statement
Short Term Group Disability Claim

The purpose of this Statement is to assist Manulife in making a decision on your patient's claim for disability benefits. When completing this form, please include sufficient details of history, physical and diagnostic findings, clinical course, therapy, and response to enable Manulife to make this decision. YOUR PATIENT WOULD APPRECIATE THE COMPLETION OF THIS FORM AS SOON AS POSSIBLE. OTHERWISE, THERE MAY BE A DELAY IN THE PROCESSING OF THIS CLAIM. PLEASE KEEP A COPY FOR YOUR RECORDS.

Manulife Group Benefits
Attention: Disability Claims
PO BOX 800 STN WATERLOO
Waterloo ON N2J 4C2

Tel: 1-877-481-9169 • (519) 747-7000
Fax: 1 866 677-4215 • (519) 579-3680
Email: group_disability_claims@manulife.com

1 Plan member/employee information and consent (To be completed by patient.)

Plan member/employee name (last, first, middle initial)	Home phone number	Cell phone number
Carpenter Wilma A.	(807) 738-2867	( )

Address (number, street, apt.)	City	Province	Postal code
Box 1998, 131 King Street	Sioux Lookout	ONT	P8T 1C3

Plan sponsor name	Plan contract number	Plan member certificate number
Nishnawbe-Aski Legal Services Corporation	110020	0000000 47

Height	Weight	Date of birth (dd/mmm/yyyy)
5'8"	192 lbs	06-June-1962

Last date worked (dd/mmm/yyyy)	Date returned to work or expected return to work date (dd/mmm/yyyy)
22-Oct-2018.	

I hereby authorize the release of medical and health information in my file to Manulife 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 may not be assessed. **I understand** that I am responsible for any fees related to the completion of this form. **I agree** that a copy or electronic version of this authorization shall be as valid as the original. **Medical and health information excludes genetic test results.**

Plan member/Employee signature _____ Date (dd/mmm/yyyy) _____

2 Attending physician's statement

STOP

NOTE TO PHYSICIAN:
- **If your patient has returned to work or will return to work within 4 weeks of the *last date worked*, complete section 2 only and sign at the end of the form.**
- **For absences expected to be greater than 4 weeks, please complete all sections in full.**

Diagnosis
Primary: Burn – moderate
Secondary: infection

If childbirth provide expected or actual delivery date (dd/mmm/yyyy) _____
Vaginal ☐ C-Section ☐

Occupational illness/injury
Is condition arising from employment? Yes ☐ No ☑

Date of first visit pertaining to this illness (dd/mmm/yyyy)	First date of work absence due to condition (dd/mmm/yyyy)
22/OCT/2018	23/OCT/2018

Hospitalization
Is/was patient hospitalized ☐ or had day surgery ☐ out-patient management
Name of institution: Mno Ya Win
Date admitted (dd/mmm/yyyy): /
Date discharged (dd/mmm/yyyy): /

If surgery was performed provide date and description of surgery.
Date (dd/mmm/yyyy): _____ Description: N/A

Treatment (drug, dosage, physiotherapy, other)
Wound care and antibiotics

Prognosis Please provide the prognosis for recovery
full recovery

3 Continuation of attending physician's statement for absences that may be greater than 4 weeks

Has the patient been treated for this condition in the past? Yes ☐ No ☑ | If *yes*, date (dd/mmm/yyyy)

Describe current symptoms, severity and frequency

Severe burn to top of (L) foot with secondary infection

Frequency of Visits ☐ Weekly ☐ Monthly ☐ Other daily dressing changes

Attach copies of all relevant:
- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed) - do not provide genetic test results**
- **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 findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations

Currently minimal wt bearing on that foot, pain, hospital daily for dressing changes, cannot work.

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

Secondary infection has delayed healing.

To your knowledge, is the patient following the recommended treatment program? Yes ☑ No ☐

In your opinion, is your patient competent to manage his/her own affairs? Yes ☑ No ☐

Prognosis Please provide the prognosis for recovery (if not previously completed in section 2)

Full recovery expected.

4 Physician's acknowledgement and authorization

I acknowledge that the information in this statement will be kept in a disability benefits file with Manulife 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 specialist	Physician's stamp
AMANDA MURDOCH	Fam. doc. CCFP	
Address (number, street, suite)		
79 5th Ave		
City	Province / Postal code	
Sioux Lookout	ON P8T 1A8	
Telephone number	Fax number	
(807) 737 3803	(807) 737 1771	
Signature	Date signed (dd/mmm/yyyy)	
	19/NOV/18	

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY CHARGE MADE FOR THE COMPLETION OF THIS FORM.

Manulife

Group Benefits
Attending Physician Statement

- **Long Term Disability Claim**
- **Waiver of Premium Claim for:**
  - **Basic & Optional Life Benefit**
  - **AD&D Benefit**
  - **Survivor Benefit**

An incomplete form may result in delays in the adjudication of your patient's disability claim.

The LTD eligibility process

In assessing eligibility for LTD benefits, we gather information from you, your patient and your patient's plan sponsor to compare restrictions and limitations with job demands.

Regrettably, incomplete forms will compromise our ability to reach a decision about this claim.

Patient authorization

Your patient is required to complete, sign and date the "Patient authorization" section at the top of page 9 before it can be submitted to Manulife.

What do we need from you?

- We need you to print clearly and answer all applicable questions.
- We need you to provide copies of consultation, progress and diagnostic investigation reports.

Payment responsibility

Your patient is responsible for payment of any fees associated with completion of this form and accompanying documentation.

Submitting forms

You may give the completed form to your patient or send it directly to Manulife, Group Disability Benefits, at the address indicated below.

Manulife Group Benefits
Attention: Disability Claims
PO BOX 800 STN WATERLOO
Waterloo ON N2J 4C2
Tel: 1-877-481-9169 or (519) 747-7000
Fax: 1-866-677-4215 or (519) 579-3680
Email: group_disability_claims@manulife.com

Manulife

Group Benefits
Attending Physician's Statement
Group Disability Claim

1 Patient authorization

To be completed by patient.

Name (last, first, initial)	Division number	Plan member certificate number
	110020	

"I hereby authorize the release to Manulife of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purpose of administering the group plan and assessing my claim. I understand that I am responsible for any fees related to the completion of this form."

Patient's signature	Date (dd/mmm/yyyy)

2 Attending physician's statement

Diagnosis

a) Primary diagnosis:

b) Additional diagnoses or complications:

c) *If* psychiatric disorder, provide current GAF score.

GAF score

d) *If* cardiac disorder, provide American Heart Association functional classification.

○ Class I (No limitation) ○ Class II (Slight limitation)
○ Class III (Marked limitation) ○ Class IV (Complete limitation)

3 Clinical information

Please note that we need your help to identify your patient's functional capabilities. Please provide copies of any chart notes and test results (excluding genetic tests) in support of your patient's diagnosis and functional abilities.

a) What date did symptoms first appear/accident happen?

(dd/mmm/yyyy)

b) When did your patient's condition begin?

(dd/mmm/yyyy)

c) Is this condition due to:

○ Injury ○ Work-related ○ Motor vehicle accident ○ Other (specify)
○ Illness

d) What is the date of the first visit, the latest visit and the frequency of visits?

Date of first visit (dd/mmm/yyyy)	Date of latest visit (dd/mmm/yyyy)

Frequency of visits

○ Weekly ○ Bi-weekly ○ Monthly ○ Other (specify)

e) What are the patient's subjective ***symptoms***?

f) How have ***symptoms*** evolved to date? (Please indicate frequency and severity)

g) What were your initial ***clinical findings***?

h) What are your most recent ***clinical findings***?

i) **Restrictions and limitations**

(i) Please comment on any physical limitations arising from this condition, including such activities as lifting, walking, standing, kneeling, sitting, repetitive movements, carrying, and so forth.

(ii) Please outline any cognitive or psychiatric limitations arising from this condition, as they relate to activities such as the following: understanding and memory, sustained concentration, social interaction, ability to work to deadlines, ability to accommodate change, and so forth.

j) Is your patient:

○ Ambulatory ○ Bed confined ○ Hospital confined
○ Ambulatory with assistive devices ○ Home confined

k) What is the patient's current height and weight, and dominant hand?

Current height	Current weight	Dominant hand
		○ Left ○ Right

l) ***If*** patient is hypertensive, provide the last 3 blood pressure readings.

Reading	Date read (dd/mmm/yyyy)
Reading	Date read (dd/mmm/yyyy)
Reading	Date read (dd/mmm/yyyy)

m) ***If*** patient is visually impaired, provide vision and date of last examination.

With corrective lenses OD	With corrective lenses OS	Without corrective lenses OD	Without corrective lenses OS	Date of last exam (dd/mmm/yyyy)

n) ***If*** patient is pregnant, give date of EDC.

Date of EDC (dd/mmm/yyyy)

4 Treatment

a) Names of other treating/consulting physicians or health care practitioners:

NAME OF PRACTITIONER	TYPE OF PRACTITIONER	DATE SEEN or TO BE SEEN (dd/mmm/yyyy)

b) Current medications

NAME	DOSAGE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

c) Other forms of treatment or therapies

TYPE	DURATION	START DATE (dd/mmm/yyyy)	RESPONSE

d) Hospitalizations:

ADMISSION DATES (dd/mmm/yyyy)	DISCHARGE DATES (dd/mmm/yyyy)	FACILITY	REASON (date of surgery if applicable)

e) Treatment response:

○ Recovered
○ Improved
○ No change
○ Retrogressed

Comments

f) Is your patient following the recommended treatment program?

○ Yes ○ No

If no, please elaborate:

g) Details of any ***proposed*** changes to the treatment plan, including date of surgery (if known), investigations, medications, therapy:

5 Competency

Do you believe that your patient is competent to endorse cheques and direct the use of the proceeds thereof?

○ Yes ○ No ***If no, from what date?***

Date (dd/mmm/yyyy)

6 Licence restriction

Has your patient's driver's licence or any other professional licence or certification been restricted or revoked as a result of the current condition?

○ Yes ○ No

○ Restricted ○ Suspended ○ Revoked

Date (dd/mmm/yyyy)

Type of licence

Class of licence (if applicable)

If yes, when will your patient be eligible to apply for reinstatement of the licence or certification?

Date (dd/mmm/yyyy)

7 Remarks

Please include any additional comments/ information that you believe may help us understand your patient's restrictions and limitations; functional capabilities; expected duration of impairment, etc.

Name of attending physician (please print)

Specialty

Telephone (include area code) ( )

Fax (include area code) ( )

Address (number, street and apartment)

City

Province

Postal code

Signature

Date signed (dd/mmm/yyyy)

The information in this statement will be kept in a group life, health, or disability benefits file with Manulife 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 you consent to such unedited release of any information contained herein.

Oct 23rd/19 1:05pm

Wilma Jocelyn → for support
Carpenter Rancourt

- niece ill in hospital; family called in
- wants to leave today
- going home to get family members
- mtg @ hospital tomorrow am.
- spoke to Michelle (Manager)
- Michelle sent to HR re: hours

75.5 S
8 1/2 days V
1 Sick

- informed Wilma to use sick time
- will convey information to Colette & Tara

D Birch