

**Submit online:**desjardinslifeinsurance.com/sendComplete and save the form on your computer first.
Keep original forms for your records.**By mail:**PO Box 1203 STN A
Toronto ON M5W 1G6Send original forms and keep copies
for your records.**By fax:**1-844-409-6571 (toll free)
416-926-0697

Keep original forms for your records.



Life • Health • Retirement

GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM**EMPLOYER STATEMENT****A - IDENTIFICATION**

We are unable to assess this claim unless all questions are answered completely.

EMPLOYEE Last name and first name Edwards, Jacqueline		Certificate or identification no.	Social insurance no.* 480 510 874
Address of employee - No., street, apt. 712 Bartleman Street,		City Timmins	Province Ontario
Postal code P4N 7PZ		Telephone no.: (705) 4 0 6 - 5 5 9 9	
E-mail address: jackieedwards11@msn.com		POLICYHOLDER OR EMPLOYER Name CINUP	
Policy or group or contract no. 641028		Division no.	
Address of policyholder or employer - No., street, suite 1805 Arthur St		City Thunder Bay	Province Ontario
Postal code P7E 2R6		Telephone no.: (807) 6 2 2 - 1 4 1 3	
Fax no.: () -		YYYY MM DD	
COMPLETE IF SELF-ADMINISTERED: Effective date of coverage:			Class no.:

* Social insurance number is necessary only if the disability claims are taxable.

B - GENERAL INFORMATIONIf the benefits are taxable, the basic tax deductions will be made.
In all other cases, please provide the appropriate tax forms.

1 Current salary <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input checked="" type="checkbox"/> Every two weeks Amount \$ 1,778.00	2 Salary effective date YYYY MM DD 2 0 1 3 - 0 6 - 1 7	3 Job status <input checked="" type="checkbox"/> Full time <input type="checkbox"/> Part time
4 Indicate days in normal work week <input type="checkbox"/> SUN <input checked="" type="checkbox"/> MON <input checked="" type="checkbox"/> TUE <input checked="" type="checkbox"/> WED <input checked="" type="checkbox"/> THU <input checked="" type="checkbox"/> FRI <input type="checkbox"/> SAT Hours worked per week 35.00	5 Type of schedule <input type="checkbox"/> Variable <input checked="" type="checkbox"/> Rotating	6 Premium paid by <input checked="" type="checkbox"/> Employer <input type="checkbox"/> Employee <input type="checkbox"/> Both
7 Date of employment YYYY MM DD 2 0 1 3 - 0 6 - 1 7	8 Occupation Community Legal Worker	9 Date last worked YYYY MM DD 2 0 2 2 - 0 5 - 2 0 No. of hours worked 7.00
10 Is disability due to an accident? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", date of accident:		
11 Did or will the employee receive any income during the disability period? (Type: holiday pay, maternity, disability, EI benefits, salary, lump sum, other) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", indicate below: Type: Amount: \$ Period:		
12 If the employee is pregnant, has an application for a preventive withdrawal been, or will it be, submitted to the CNESST (Québec only)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
13 Has a claim been filed with a government agency? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", indicate below: <input type="checkbox"/> CNESST / WCB / WSIB / WHSCC <input type="checkbox"/> CPP / QPP <input type="checkbox"/> SAAQ (Québec only) <input type="checkbox"/> Other, specify: _____ YYYY MM DD Date Filed: Decision Rendered: Amount: \$		
14 Has the employee returned to work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes", on what date? YYYY MM DD		
15 Is this person still in your employ? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No - Termination date: _____ Reason: _____		
16 Was this person given a record of employment? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
17 Are there any work-related factors that may have contributed to the employee's disability or had an impact on their return-to-work? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes - Please specify: _____		
18 Is your employee eligible for an exemption under the Indian Act (R.S.C. (1985), c. I-5)? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If so, please indicate the percentage of employment income that is not taxable: 100.00 %		

PLEASE COMPLETE THE BACK OF THE FORM.

C - PHYSICAL WORK ENVIRONMENT

Please attach a brief job description if available.

1 What are the main duties of the employee's job and how much time is allocated to each one weekly?

Duties	Admin - high volume of calls/referrals/immediate serv	60 %	Duties	Travel to communities, assist clients, presentations	10 %
Duties	Travel - courts	30 %	Duties		%

For questions 2 and 3, **FREQUENCY** is defined as follows:

OCCASIONALLY: 0-15 % of the times **FREQUENTLY:** 16-50 % of the time **ALWAYS:** 51 % + of the time

2 Work environment - Does the employee's job require work in any of the following conditions?

FREQUENCY:	O	F	A	FREQUENCY:	O	F	A	FREQUENCY:	O	F	A
<input type="checkbox"/> Outside	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> In a damp or humid environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Above or below ground level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In extremes of cold or heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Toxic fume	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Handling chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does the job involve other hazards? Yes No If "Yes", please list:
 N/A

3 Check the items below that relate to the employee's job, and complete the information requested.

FREQUENCY:	O	F	A	FREQUENCY:	O	F	A	FREQUENCY:	O	F	A
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Bending over	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Extending/reaching above head	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/> Stairs (No. of steps <u>20</u>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keeping one's balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ladders (Height _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DESCRIBE ACTIVITY AND SPECIFY FREQUENCY AND WEIGHT:	FREQUENCY:	O	F	A	WEIGHT:
<input type="checkbox"/> Pushing _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lb <input type="checkbox"/> Kg
<input type="checkbox"/> Pulling _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lb <input type="checkbox"/> Kg
<input type="checkbox"/> Lifting/carrying _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Lb <input type="checkbox"/> Kg

Please list any office equipment, motor vehicle, tools or other equipment that is used in the employee's job.

Type of equipment	Computer/mouse/keyboard	Times per day	80% of the day
Type of equipment	Vehicle	Times per day	at least 1 time per day

4 Does the employee work in an extremely noisy environment, have to work at a fast pace, do repetitive movements or have short deadlines? Yes No

If "Yes", please specify: _____
 The employee works in the courts, on the phone and in the office with clients. Many tasks are repetative in nature and move fast at times depending on the needs of the client. Very often there are short deadlines for clients and providing services for clients. This is a high volume, timesesitive role that requires a lot of critical thinking.


5 Does the employee's job require dexterity? Yes No

If "Yes", please specify: _____
 The employee is required to spend a lot of time on the computer and writing reports.

D - ADDITIONAL INFORMATION

This position requires the employee to work fast, do a lot of critical thinking for clients and often must meet short deadlines to ensure clients meet their court deadlines.

SIGNATURE OF THE AUTHORIZED PERSON

SHWETZ, COLETTE	HR Manager
Last name and first name of the authorized person (IN BLOCK LETTERS)	Position
cshwetz@nanlegal.on.ca	
E-mail address	
	<u>May 26/22</u>
Signature	Date

MISIWAY
Milopemahtesewin



Community Health Centre
130 Wilson Avenue
Timmins, ON P4N 2S9
Phone: 705-264-2200
Fax: 705-267-5688

CLINIC FAX COVER SHEET

To: _____ Attention: _____

Date: May 24, 22 Fax #: 705-268-8012

Re: _____

Number of pages (including cover sheet): _____

=====

As requested For your information Please reply Originals to follow

=====

- | | |
|---|--|
| <input type="checkbox"/> Dr. P. Critchley, Physician | <input type="checkbox"/> Christle Lackie, RN, CDE |
| <input type="checkbox"/> Dr. L. Marion-Bellemare, Physician | <input type="checkbox"/> Melanie Ricard, Adm. Assistant |
| <input type="checkbox"/> Rachel Cull, Executive Director | <input type="checkbox"/> Julie Corbett, Adm. Assistant |
| <input type="checkbox"/> Lorna Cooper, Nurse Practitioner | <input type="checkbox"/> Elizabeth McLeod, Health Promoter |
| <input type="checkbox"/> Wanda Carleton, Nurse Practitioner | |
| <input type="checkbox"/> Elizabeth Mills, Nurse Practitioner | |
| <input type="checkbox"/> Tracey Koostachin, R.N. | |
| <input type="checkbox"/> Joe-Anne Chaput, Clinic Coordinator | |
| <input type="checkbox"/> Angie Bourgeois, Indigenous Outreach Navigator | |
| <input type="checkbox"/> Hillary Deyne, Registered Dietician | |

Message:

This facsimile and its contents are confidential, and are intended only for the persons named above. If you have received this facsimile in error, please notify the sender immediately by telephone and securely dispose of the documents. Any reading, distribution, or disclosure of this message if you are not the intended recipient is strictly prohibited. Thank you.



EMPLOYEE DISABILITY CHECKLIST

Please complete the enclosed forms in full, and in ink. Ensure all forms are signed and dated where applicable.

- o *Direction and Authorization Form*
- o *Employee Statement*
- o *Attending Physician's Statement (take full package to your attending physician who will complete the appropriate form)*
- o *Void cheque :*

Mail, fax or email completed forms to:

Mail: **JG Benefits Inc.
1051 King Edward Street
Winnipeg, MB R3H 0R4**

Fax: **1-833-702-4687**

Email: **disability@cinup.ca**

Should you have any questions, please contact the CINUP Disability team at 1-800-665-1234

Direction and Authorization Form

DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION

FROM Jacqueline Edwards
Employee's (Claimant Name)

TO Desjardins Financel

RE RELEASE OF CONFIDENTIAL/PERSONAL INFORMATION TO JG Benefits Inc./CINUP (hereinafter "Policyholder")

INDIVIDUAL POLICY NUMBER : Select Policy Number
641028

I hereby direct and authorize the company to discuss with the Policyholder (JG Benefits Inc./CINUP) any and all information or documentation concerning my claim and its evaluation by the company, including but not limited to, any medical, financial, vocational, rehabilitation, or any other confidential/personal information or documentation concerning my claim. I also authorize the Company (Desjardins Financel) to send to the policyholder, copies of correspondence the Company receives from me concerning my claim as well as any medical information received from external sources.

Duration and Revocation

I understand that

- It is not a requirement of the Policy/Policies that I authorize the company to disclose information to the Policyholder
- This authorization will remain valid for as long as I am claiming benefits or service from the Company; and,
- I am free to revoke this authorization at any time by sending written notice to the Company of such revocation.

I have read and understand the above. I am signing this voluntarily, and not under compulsion by anyone.

Jacqueline Edwards
Signature of Claimant

May 13/22
Date

Employee Statement



Submit online:
desjardinslifeinsurance.com/claim
Complete and save the form on your computer first.
Keep original forms for your records.



By mail:
PO Box 1503 STN A
Toronto ON M5W 1G8
Send original forms and keep copies
for your records.



By fax:
1-844-409-6571 (toll free)
416-828-0897
Keep original forms for your records.

Contact us: 1-800-263-1810 (toll free) or 416-828-2860



GROUP INSURANCE - DISABILITY CLAIMS

DISABILITY OR WAIVER OF PREMIUM CLAIM
EMPLOYEE STATEMENT

The payment of your disability claim will be made by direct deposit only. Please include a specimen cheque marked «VOID».

A - IDENTIFICATION We are unable to assess this claim unless all questions are answered completely.

Last name and first name of employee Edwards Jacqueline		Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Date of birth MM DD YY 1967 01 19
Address - No., street, apt. 713 Bantleman Street		City Timmins	Province Postal code ON P4N 7P2
Policy or group or contract no. 841028	Division no. 59086	Certificate or identification no. 68874	Social Insurance no. ¹ 480 510 874

Telephone no. (mandatory): **(705) 406-5599** I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me
voluntarily about my disability claim.

E-mail address²: **jackieedwards11@msn.com**

¹ Your social insurance number is necessary only if your disability claims are taxable. Please contact your employer to obtain this information.
² Please provide this information only if you authorize Desjardins Insurance to email you.

B - GENERAL INFORMATION

1. Training: **CPR, WMS, COACH, CUSTOMER SERVICE, PROFSOFT (LEGAL AID), HR**

Level of education: **OFFICE ADMINISTRATION - 2 YRS DIPLOMA**

Work experience: **COMMUNITY LEGAL WORKER - EMPLOYED SINCE
JUNE 2013 UNTIL PRESENT**

Spoken language: English French Written language: English French

2. Is disability due to an accident? Yes No If "Yes", date of accident: MM YY Time Type of accident

AM PM Work-related Motor vehicle Other

Indicate details (where, how):

3. Did you receive prior treatment for the illness or injury causing the disability? Yes No
If "Yes", give particulars including name, address and telephone number of all treating physicians and specialists:

4. Name, address and telephone number of physicians and specialists who have treated you during the disability:

PLEASE COMPLETE THE BACK OF THE FORM.
06329E01 (2018-11) Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

B - GENERAL INFORMATION (CONTINUED)

5. If you have any accident or sickness coverage through a union, society, creditor, mortgage, auto, lodge or other association, through another employer, under an individual policy, give the following particulars:

Name of insurer	Policy no.	Certificate no.	Start date of benefits YYYY MM DD	End date of benefits YYYY MM DD	Benefit amount	Weekly/Monthly
					\$	<input type="checkbox"/> W <input type="checkbox"/> M
					\$	<input type="checkbox"/> W <input type="checkbox"/> M

Comments: _____

C - DIRECT DEPOSIT ENROLLMENT Please include a specimen cheque marked "VOID".

I hereby authorize Desjardins Insurance to deposit my benefit payment through the DIRECT DEPOSIT system into account at the financial institution indicated below:

Name of financial institution	Institution no.	Transit/branch no.	Account no.
<u>NORTHERN CREDIT UNION</u>	<u>051</u>	<u>61792</u>	<u>100001357659</u>
Address - No., street, suite	City	Province	Postal code
<u>70 MOUNTAIN ST NORTH</u>	<u>TIMMINS</u>	<u>ON</u>	<u>P4N 4Y7</u>

Any credit entered in my account in accordance with this authorization will be identified with a DIRECT DEPOSIT transaction code and I acknowledge that the credit in question shall constitute an amount paid in accordance with this authorization.

This authorization will be effective on _____ . The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me.

Signature of employee: Jaqueline Edwards Date: May 13/22

D - PERSONAL INFORMATION MANAGEMENT

Desjardins Insurance handles the personal information it has on you in a confidential manner. Desjardins Insurance keeps this information on file so that you may benefit from group insurance services offered by the Company. This information is consulted solely by Desjardins Insurance employees who need to do so in the course of their work. Desjardins Insurance may compile anonymized personal information for statistical and informational purposes. Desjardins Insurance may also communicate with plan members to provide them with optimal health management. You have the right to consult your file. You may also have information corrected if you demonstrate that it is inaccurate, incomplete, ambiguous or not useful. To do so, you must send a written request to the following address: Privacy Officer, Desjardins Insurance, 200, rue des Commandeurs, Lévis, Québec, G6V 6R2. Desjardins Insurance may use the client list to offer its clients an insurance product following the termination of their group insurance. If you do not wish to receive these offers, you may have your name removed from the list. To do so, you must send a written request to the Privacy Officer at Desjardins Insurance.

E - DECLARATION AND AUTHORIZATION FOR THE COLLECTION AND COMMUNICATION OF PERSONAL INFORMATION

To be completed for each claim.

I hereby certify that the above answers are full and true. I authorize Desjardins Insurance solely for the purposes of determining my insurability, managing my file and settling my claims to: (a) collect from any person or legal entity, or from any public or parapublic organization, only the information deemed necessary to manage my file. The non-exhaustive list of sources from which information may be collected includes healthcare professionals or institutions, the MIB (formerly known as Medical Information Bureau), insurance companies, personal information officers or investigation agencies, the policyholder, my employer or former employers; (b) communicate to the said persons or organizations only the personal information about me that is deemed necessary for the purposes of my file; (c) when necessary, request an inquiry report about me, and also use the personal information it may have about me in existing files that are now closed.

Provided that I have filled out the appropriate boxes, I authorize Desjardins Insurance to email me at the address provided in section A of this form and I give Desjardins Insurance permission to leave voicemail about my disability claim at the phone number provided on this form.

I authorize Desjardins Insurance to use or communicate my social insurance number for tax purposes. A photocopy of this authorization is as valid as the original.

Signature of employee: Jaqueline Edwards Date: May 13/22

VERY IMPORTANT

Please have the initial attending physician's statement completed and submit the completed forms online, or by mail or fax to: Desjardins Insurance - Disability Claims.



Submit online
Visit www.desjardins.com/health
Complete and save the form on your computer first.
Keep original forms for your records.



By mail
PO Box 1703 STM A
Toronto ON M5W 1G9
Send original forms and keep copies for
your records.



By fax
1-844-429-6371 (toll free)
416-924-0637
Keep original forms for your records.



INITIAL ATTENDING PHYSICIAN'S STATEMENT PSYCHIATRIC/PSYCHOLOGICAL FORM

- 1 PLEASE PRINT.
- 2 PART 1 to be completed by patient.
- 3 PART 2 to be completed by physician.
- 4 Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT) _____
 Policy or group or contract no. 641028 Certificate or identification no. _____ Date of birth _____

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any psychiatric/counselor consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (please use DSM-IV criteria)

Complicated Grief
Supporting data:
Please describe the symptoms (severity and frequency), that support each side of your diagnosis.

- 1.1 Axis I: Complicated Grief
- 1.2 Axis II: None
- 1.3 Axis III: None
- 1.4 Axis IV: Loss of family
- 1.5 Axis V - Current GAF score: 8

2. History

- 2.1 When did symptoms start and/or worsen? May 1, 2022
- 2.2 Date patient's condition first prevented them from working? May 9, 2022
- 2.3 Date of first visit for treatment or consultation: May 9, 2022
- 2.4 Has patient ever had same or similar condition? Yes No Unknown If yes, state when and describe:

2.5 Were work problems a factor in the development of your patient's disorder? Yes No If yes, please describe:

2.6 Has a claim been filed with the Workers Compensation Board? Yes No

2.7 Date of latest visit: May 9, 2022

2.8 Frequency of visits: Weekly Monthly Other: 9-10 weeks

2.9 Are patient's symptoms due to drug or alcohol abuse? Yes No

2.10 If yes, is patient enrolled in a substance abuse program? Yes No If yes, state facility:

2.11 Has your patient ever been enrolled in a substance abuse program? Yes No If yes, state when:

3. Treatment for psychiatric/psychological illness

- 3.1 Is patient seeing or being referred to a psychiatrist? Yes No If yes, name of psychiatrist: but to counselling
- 3.2 If pending, is there an appointment date? Yes No If yes, date: _____
- 3.3 Is patient seeing or being referred to a therapist? Yes No If yes, name of therapist: appointment pending
- 3.4 Date of hospital inpatient admission: _____ Date of discharge: _____
Name of hospital: _____

4. Predisposing and complicating factors

Please describe all factors that may have contributed to the onset of the clinical problem(s) or may complicate their resolution.

- Workplace issues
- Social/Family issues
- Physical/Mental condition
- Financial/Legal problems
- Coping skills
- Alcohol/Drug abuse
- Personality/Intoxication
- Other issues

Comments: Death of family members

5. Current treatment

- 5.1 Therapy method: counselling services
- 5.2 Therapy goal: help control
- 5.3 Frequency and length of therapy/counselling sessions: appointments - biweekly
- 5.4 Number of therapy/counselling sessions to date: _____
- 5.5 Treatment compliance: _____
- 5.6 Treatment response to date: _____
- 5.7 Prognosis and time frame of illness: _____

Medications:	Medication name			
	Date started			
	Initial dosage			
	Initial response			
	Date of last dosage change			
	Current dosage			
	Response			
	Side effects			
	Compliance			
	Date medication discontinued			

6. Future treatment plans

What changes to your treatment plan are underway or are being considered?

7. Return to work plans

- 7.1 Prognosis for recovery: 12-16 weeks good prognosis
- 7.2 Expected date patient will return to their own occupation: Asap
- 7.3 If unknown, please indicate the next follow up date: _____
- 7.4 If your patient is unable to return to their regular occupation, please specify when and under what circumstances they could return to work (eg. modified duties, gradual return to work): _____
- 7.5 Have return to work time lines been discussed with the patient? Yes No
- 7.6 Please elaborate on time frames and patient's response: good response
- 7.7 Is your patient a suitable candidate for vocational rehabilitation? Yes No (If yes, please specify: _____)
- 7.8 When and under what circumstances could patient return to modified duties or a gradual return to work? _____

8. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition, treatment requirements, and motivation to return to work?

9. Identification of physician

9.1 Last name and first name (PLEASE PRINT) _____ S.2 Specialty _____ License no. _____

9.3 Address - No., street, suite _____ City _____ Province _____ Postal code _____

9.4 Telephone no.: (_____) _____ Fax no.: (_____) _____

Signature of physician: [Signature] Date: _____

Please direct all pertaining correspondence to:
 Dr. L. Marion-Bellemare, MISIWAY CHC
 130 Wilson Ave. Timmins, ON P4N 2S9
 Phone: 705-264-2200 Fax: 705-267-5688
 Thank you for cooperation

JACQUELINE EDWARDS
713 BARTLEMAN
TIMMINS, ON
P4N 7P2


051


DATE 2 0
Y Y Y Y M M D D

PAY TO THE
ORDER OF

\$

100 DOLLARS

 Security features
only here.
Details on back.

 NORTHERN CREDIT UNION 70 MOUNTJOY STREET NORTH TEL: (705) 267-6844
TIMMINS, ONTARIO P4N 4V7

MEMO

⑈05⑈ ⑆6⑆792⑈828⑆ 100001257⑈559⑈

VOID

Attending Physician Statement

(Please take full package to your physician)



GROUP INSURANCE - DISABILITY CLAIMS

IMPORTANT NOTE TO CLAIMANT

In order to avoid any delays in the assessment of your claim, please have your physician complete the appropriate Initial Attending Physician's Statement form:

- General	Form no. 12018E01
- Musculo-skeletal	Form no. 12019E01
- Psychiatric/psychological	Form no. 12020E01
- Cardiac	Form no. 12021E01
- Cancer	Form no. 12022E01

We have sent you all five of the above-mentioned Initial Attending Physician's Statement forms, each of which is specific to a particular illness. Please give all five forms to your physician so they can fill out the appropriate one.

It is important that your physician fully complete the form that best corresponds to your medical condition to ensure your claim is processed promptly.

Short Term Disability: Return the complete form to Desjardins Financial Security Life Assurance Company, hereinafter Desjardins Insurance, as soon as possible.

Long Term Disability: Return the complete form to Desjardins Insurance no later than six weeks prior to the start of your long-term disability period.

Online: desjardinslifeinsurance.com/send

Desjardins Insurance
PO Box 1203 STN A
Toronto ON M5W 1G6

Fax: 416-926-0697 or 1-844-409-8571



Submit online:
Desjardins Insurance Form 6662
Complete and save the form on your computer first.
Keep original forms for your records.



By mail:
PO Box 1203 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for
your records.



By fax:
1-844-439-6371 (toll free)
416-978-0657
Keep original forms for your records.



INITIAL ATTENDING PHYSICIAN'S STATEMENT
GENERAL FORM

- PLEASE PRINT
PART 1 to be completed by patient.
PART 2 to be completed by physician.
Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT)
Policy or group or contract no.
Certificate or identification no.
Date of birth

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (including complications) - If psychiatric, give DSM-IV code.
1.1 Primary:
1.2 Secondary:
1.3 Subjective symptoms (including severity, frequency, duration):
1.4 Findings (please enclose a copy of current x-rays, EKGs, laboratory data, blood pressure and any other relevant clinical findings):
1.5 Degree of severity of all symptoms: Mild Moderate Severe With psychotic elements
2. History
2.1 Date symptoms first appeared or accident happened:
2.2 Date patient's condition first prevented them from working:
2.3 Has this patient ever had same or similar condition? Yes No Unknown
If yes, please specify diagnosis and dates of treatments:
2.4 Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown
2.5 Have Worker's Compensation/CST forms been completed? Yes No Unknown
2.6 If patient is pregnant, give E.O.C.:
2.7 Names and specialties of other treating physicians:
2.8 Current height: Current weight: Weight loss/gain to date:
3. Treatment dates
3.1 Date of first visit for current condition: 3.5 Date of discharge:
3.2 Date of latest visit: 3.6 Date of out-patient treatment:
3.3 Frequency of visits: Weekly Monthly Other (specify):
3.7 Name of hospital:
3.4 Date of in-patient admission:
4. Nature of treatment
4.1 Medications (dose, frequency, date prescribed):
4.2 Surgeries (including dates):
4.3 Other (including frequency):
4.4 Is patient following recommended treatment program? Yes No (please elaborate):

5. Progress

- 5.1 Has patient: Recovered Improved Not improved Retrogressed
- 5.2 Current status: Ambulatory Home confined Bed confined Hospital confined

6. Restrictions and limitations

		HOURS AT ONE TIME					TOTAL HOURS DURING THE DAY					
		<1	<2-3	<2-4	4-6	6-8	<1	<1-2	<2-4	4-6	6-8	
6.1 Stand	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.2 Walk	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.3 Walk on uneven surfaces	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.4 Sit	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.5 Drive	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
6.6 This patient can lift/carry a maximum of:		lbs	0	8	9	14	18	22	27	32	35	41*
		lbs	0	10	20	30	40	50	60	70	80	90*
6.7	<input type="checkbox"/> No restriction <input type="checkbox"/> Repetitively how much? <input type="checkbox"/> Occasionally how much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.8 Please indicate in the space provided if this patient is able to perform the following actions: Frequently (F), Occasionally (O), or Not at all (N):
 Drive: _____ Bend: _____ Squat: _____ Kneel: _____ Climb: _____ Reach (above shoulder): _____ Reach (below shoulder): _____

7. Psychiatric illness (if applicable)

- 7.1 History: _____
- 7.2 Precipitating chronological events: _____
- 7.3 Work issues related to this illness: _____
- 7.4 Pre-morbid personality: _____
- 7.5 Changes in ADL habits: _____
- 7.6 Familial risk factors: _____
- 7.7 Progress with treatment plans: _____
- 7.8 Are patient's symptoms related to drug or alcohol abuse? Yes No
 If yes, is patient enrolled in a substance abuse program? Yes No If yes, state facility: _____
- 7.9 Has your patient ever been enrolled in a substance abuse program? Yes No If yes, state when: _____

B. Return to work plans

- 8.1 Prognosis for improvement or recovery: _____
- 8.2 Expected date patient will return to their own occupation: _____
- 8.3 If unknown, please indicate the next follow up date: _____
- 8.4 If your patient is unable to return to their own occupation, please specify when and under what circumstances they could return to modified duties or gradual return to work: _____
- 8.5 Have return to work time lines been discussed with the patient? Yes No
- 8.6 Please elaborate on time frames and patient's response: _____

9. Rehabilitation

- 9.1 Is patient a suitable candidate for medical rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc): Yes No
 If yes, please specify: _____
- 9.2 Is patient a suitable candidate for vocation rehabilitation? Yes No If yes, please specify: _____

10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT) _____ 11.2 Specialty _____ License no. _____

11.3 Address - No., street, suite _____ City _____ Province _____ Postal code _____

11.4 Telephone no. () _____ Fax no. () _____

Signature of physician: _____ Date: _____



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INITIAL ATTENDING PHYSICIAN'S STATEMENT MUSCULO-SKELETAL FORM

- 1 PLEASE PRINT.
- 2 PART 1 to be completed by patient.
- 3 PART 2 to be completed by physician.
- 4 Any change for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT) _____
 Policy or group or contract no. 641028 Certificate or identification no. _____ Date of birth _____

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed education decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. **Diagnosis**
- 1.1 Primary: _____
- 1.2 Secondary: _____
- 1.3 Date symptoms first appeared: _____
- 1.4 Date patient's condition first prevented them from working: _____
- 1.5 Date of first visit for treatment or consultation: _____
- 1.6 Has patient ever had the same or similar condition? Yes No Unknown (If yes, state when and describe: _____)
- 1.7 Is condition a result of an injury due to an accident? Yes No (If yes, please describe: _____)
- 1.8 Current height: _____ Current weight: _____ Weight loss/gain to date: _____
- 1.9 Is condition due to injury or sickness arising out of patient's employment? Yes No Unknown
If yes, have Worker's Compensation/CNESST forms been completed? Yes No
- 1.10 Date of latest visit: _____
- 1.11 Frequency of visits: Weekly Monthly Other (specify): _____
- 1.12 Date of hospital inpatient admission: _____
- 1.13 Date of discharge: _____
- 1.14 Date of hospital outpatient admission: _____
- 1.15 Name of hospital: _____
- 1.16 Other treating physicians: _____
- 1.17 Pending referrals to specialists: _____

2. Studies

Please outline all objective studies performed/scheduled (X-rays, laboratory data, CT scans, etc.) and attach copies of each report.

Date	Procedure	Results

3. Symptoms and signs

Please indicate the nature and severity of the patient's symptoms and signs.

Please specify location(s) and physical findings	Severe	Moderate	Mild	Asympt
	Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deformity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle spasm	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle atrophy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of tendon reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor deficit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Straight leg raising limitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Range of motion limitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

if arthralgic condition: In remission Continuously active Stable Occasionally active Intermittently active Progressive

if fracture: Closed Depressed Open Compressed Comminuted

4. Nature of treatment

4.1 Medications (dose, frequency, date prescribed): _____

4.2 Physiotherapy (type, frequency, dates): _____

4.3 Surgery date (past): _____ Surgery date (future): _____

4.4 Other treatment: _____

4.5 Is patient compliant with prescribed measures? Yes No if no, please explain: _____

5. Restrictions and limitations

		HOURS AT ONE TIME TOTAL					HOURS DURING THE DAY				
		<1	<1-2	<2-4	4-6	6-8	<1	<1-2	<2-4	4-6	6-8
6.1 Stand	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.2 Walk	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.3 Walk on uneven surfaces	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.4 Sit	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.5 Drive	<input type="checkbox"/> No restriction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.6 This patient can lift/carry a maximum of	lbs	0	5	9	14	18	24	27	32	36	41+
	lbs	0	10	20	30	40	50	60	70	80	90+
6.7	<input type="checkbox"/> No restriction <input type="checkbox"/> Repetitively how much? <input type="checkbox"/> Occasionally how much?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6.8 Please indicate in the space provided if this patient is able to perform the following actions: Frequently (F), Occasionally (O), or Not at all (N):
 Drive: Bend: Squat: Kneel: Climb: Reach (above shoulders): Reach (below shoulders):

6. Prognosis and return to work plans

6.1 Prognosis for recovery: _____

6.2 Expected date patient will return to their own occupation: _____

6.3 If unknown, please indicate the next follow up date: _____

6.4 If your patient is unable to return to their own occupation, please specify when and under what circumstances they could return to modified duties or gradual return to work: _____

6.5 Have return to work time issues been discussed with the patient? Yes No

6.6 Please elaborate on time frames and patient's responses: _____

7. Progress

7.1 Has patient: Recovered Improved Not improved Regressed

7.2 Current status: Ambulatory House confined Bed confined Hospital confined

8. Assessment and treatment are complicated by: (please select and explain in the space provided below)

- 8.1 Significant emotional or behavioural disorder such as depression, anxiety, etc.
- 8.2 Exaggeration, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations.
- 8.3 Work related issues (please describe if known): _____
- 8.4 Substance abuse: _____
- 8.5 Other (please describe): _____

9. Rehabilitation

- 9.1 Is patient a suitable candidate for medical rehabilitation services? Yes No
 - 9.2 Is patient a suitable candidate for vocation rehabilitation? Yes No
- If yes to either of the above, please specify: _____

10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT)		11.2 Specialty	License no.
11.3 Address - No., street, suite	City	Province	Postal code
11.4 Telephone no.: () -		Fax no.: () -	
Signature of physician:		Date:	



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INITIAL ATTENDING PHYSICIAN'S STATEMENT CARDIAC FORM

- 1. PLEASE PRINT.
- 2. PART 1 to be completed by patient.
- 3. PART 2 to be completed by physician.
- 4. Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT) _____
 Policy or group or contract no. _____ Certificate or identification no. _____ Date of birth _____
 041028

PART 2 - Attending physician's statement

It is very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (including complications) - If psychiatric, give DSM-IV code.

1.1 Primary: _____

1.2 Secondary: _____

1.3 Date symptom(s) first appeared: _____

1.4 Date patient's condition first prevented them from working: _____

1.5.1 Date of first visit: _____ 1.5.2 Date of latest visit: _____

1.6 Frequency of visits: Weekly Monthly Other (specify): _____

1.7.1 Date of in-patient admission: _____ 1.7.2 Date of discharge: _____

1.8 Date of out-patient treatment: _____

1.9 Name of hospital: _____

1.10 Subjective symptoms (including severity/frequency/duration): _____

2. Findings

2.1 Chest pain of cardiac origin Syncope Fatigue Dyspnea due to vascular congestion or hypoxia Psychophysiology
 Other (please specify): _____

2.2 ECG readings over the last 6 months (including dates): _____

2.3 Current height: _____ Current weight: _____ Weight loss/gain to date: _____

2.4 Current status: Stable Improving Regressing.

3. Laboratory tests (completed/scheduled) - Please include copies of relevant test results.

- a) ECG: _____ e) Blood test: _____
- b) Echocardiogram: _____ f) X-rays: _____
- c) Stress thallium test: _____ g) Angiogram: _____
- d) Pulmonary function test: _____

4. Treatment

4.1 Medications (dose, frequency, date prescribed): _____

4.2 Other (please describe): _____

4.3.1 Surgery date (past): _____ 4.3.2 Surgery date (future): _____

4.4 Other treating physicians: _____

4.5 Is patient compliant with prescribed treatment? Yes No If no, please explain: _____

4.6 Has your patient been enrolled in a cardiac rehabilitation program? Yes No If yes, provide details: _____

5. Restrictions and limitations

5.1 Functional capacity (Canadian Cardio-Vascular Society (CCS))

Level 1 (no limitation) Level 2 (mild impairment) Level 3 (moderate impairment) Level 4 (severe impairment)

5.2 Functional capacity:

Lifting/Carrying <input type="checkbox"/> 1-10 (0.5 - 4.5 kg) <input type="checkbox"/> 11-20 (5.0 - 9.1 kg) <input type="checkbox"/> 21-30 (9.5 - 22.7 kg)	Frequency: _____ Duration: _____
Pushing/Pulling <input type="checkbox"/> 1-10 (0.5 - 4.5 kg) <input type="checkbox"/> 11-20 (5.0 - 9.1 kg) <input type="checkbox"/> 21-30 (9.5 - 22.7 kg)	Frequency: _____ Duration: _____
Standing: _____ hours Walking: _____ blocks Driver's license revoked: <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequency: _____ Duration: _____

5.3 What specific restrictions or limitations prevent the patient from performing the duties of his/her occupation? _____

5.4 How does this affect the patient's ability to perform activities of daily living? _____

6. Return to work plans

6.1 Prognosis for medical recovery: _____

6.2 Expected date patient will return to their own occupation: _____

6.3 If unknown, please indicate the next follow up date: _____

6.4 If your patient is unable to return to their own occupation, please specify when and under what circumstances they could return to modified duties or gradual return to work: _____

7. Assessment and treatment are complicated by: please select and explain in the space provided below.

- 7.1 Significant emotional or behavioral disorder such as depression, anxiety, etc.
- 7.2 Divergence, inconsistent findings, subjective complaints out of proportion to objective findings, bizarre or contradictory observations
- 7.3 Work-related issues (please describe if known): _____
- 7.4 Substance abuse
- 7.5 Other (please describe): _____

8. Progress

8.1 Has patient: Recovered Improved Not improved Regressed

8.2 Current status: Ambulatory House confined Bed confined Hospital confined

9. Rehabilitation

9.1 Is patient a suitable candidate for medical rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc): Yes No
if yes, please specify: _____

9.2 Is patient a suitable candidate for vocation rehabilitation? Yes No if yes, please specify: _____

10. Comments

Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT)	11.2 Specialty	License no.
11.3 Address - No., street, suite	City	Province
		Postal code
11.4 Telephone no.: () -	Fax no.: () -	
Signature of physician:	Date:	



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INITIAL ATTENDING PHYSICIAN'S STATEMENT CANCER FORM

- 1 PLEASE PRINT.
- 2 PART 1 to be completed by patient.
- 3 PART 2 to be completed by physician.
- 4 Any charge for completion of this form is the patient's responsibility.

PART 1 - Identification of patient

Last name and first name (PLEASE PRINT)

Policy or group or contract no.
641028

Certificate or identification no.

Date of birth

PART 2 - Attending physician's statement

It can be very helpful in facilitating a timely comprehensive informed adjudication decision to have your full clinical notes from the date of disability and any consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (including any complications) - Please attach a copy of all consultation, operative and pathology reports.

- 1.1 Date of cancer diagnosis: _____
- 1.2 Site of the tumour: _____
- 1.3 Type of tumour: _____
- 1.4 Histology and staging: _____
- 2. History
- 2.1 Date symptoms first appeared: _____
- 2.2 Has this patient ever had same or similar condition? Yes No Unknown
If yes, please specify diagnosis and date of treatment: _____
- 2.3 Describe current symptoms: _____
- 2.4 First visit for these symptoms: _____
- 2.5 Current height: _____ Current weight: _____ Weight loss/gain to date: _____
- 2.6 In your opinion, when did the patient's condition first prevent them from working?

3. Treatment

- 3.1 Date of first visit: _____
- 3.2 Date of latest visit: _____
- 3.3 Frequency of visits: Weekly Monthly Other (specify): _____
- 3.4 Treatment - include information on all treatments to date and future treatment plan, inclusive of:
 - a) Surgery: _____
 - b) Radiation: _____
 - c) Hormones: _____
 - d) Chemotherapy: _____

4. Hospitalization (if applicable for this illness or injury)

- 4.1 Date of in-patient admission: _____
- 4.2 Date of discharge: _____
- 4.3 Date of out-patient treatment: _____
- 4.4 Name of hospital: _____

5. Therapies

5.1 Describe the therapies to date: N/A Partial Complete

5.2 Describe all co-morbid conditions: _____

5.3 Describe any post therapy sequelae: _____

5.4 Please provide the patient's prognosis for improvement and/or recovery: _____

5.5 Is the condition due to injury or sickness arising out of the patient's employment? Yes No

6. Patient's current physical abilities

6.1 Please indicate your patient's current physical abilities:

- Sedentary duties: Mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.
- Light duties: Frequent handling of loads of up to 5 kg, sometimes up to 11 kg may require frequent walking or standing, or sitting with a degree of pushing and pulling of arm and/or leg controls.
- Medium duties: Frequent handling of loads up to 11 kg, sometimes up to 23 kg. Frequent lifting, carrying, pushing and pulling may also be required.
- Heavy duties: Frequent handling of loads up to 23 kg, sometimes up to 45 kg.

6.2 In your opinion, what is the earliest date your patient will be able to return to work? _____

6.3 If the previous job could be modified, when could rehabilitation employment commence? _____

7. Comments

7.1 Please provide the names of other physicians who have been/will be involved in assessing the medical problems and copies of any available consultation reports: _____

7.2 We would appreciate any additional comments that would help us to better understand your patient and their condition: _____

8. Identification of physician

8.1 Last name and first name (PLEASE PRINT)		8.2 Speciality	8.3 License no.
8.4 Address - No., street, suite	City	Province	Postal code
8.4 Telephone no.: () -		Fax no.: () -	
Signature of physician:		Date:	

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| <input type="checkbox"/> Dr. L. Marion-Bellemare, Physician | <input type="checkbox"/> Melanie Ricard, Adm. Assistant |
| <input type="checkbox"/> Rachel Cull, Executive Director | <input type="checkbox"/> Julie Corbett, Adm. Assistant |
| <input type="checkbox"/> Lorna Cooper, Nurse Practitioner | <input type="checkbox"/> Elizabeth McLeod, Health Promoter |
| <input type="checkbox"/> Wanda Carleton, Nurse Practitioner | <input type="checkbox"/> Tom Dolanjski, PCP Pharmacist |
| <input type="checkbox"/> Elizabeth Mills, Nurse Practitioner | |
| <input type="checkbox"/> Tracey Koostachin, R.N. | |
| <input type="checkbox"/> Joe-Anne Chaput, Clinic Coordinator | |
| <input type="checkbox"/> Angie Bourgeois, Indigenous Outreach Navigator | |
| <input type="checkbox"/> Hillary Deyne, Registered Dietician | |

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CLINIC FAX COVER SHEET

To: _____ Attention: _____
 Date: _____ Fax #: 833-702-4687
 Re: _____

Number of pages (including cover sheet): 21
 As requested For your information Please reply Originals to follow

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- Dr. L. Marlon-Bellemare, Physician
- Rachel Gull, Executive Director
- Lorna Cooper, Nurse Practitioner
- Wanda Carleton, Nurse Practitioner
- Elizabeth Mills, Nurse Practitioner
- Tracey Koostachin, R.N.
- Joe-Anna Chaput, Clinic Coordinator
- Angie Bourgeois, Indigenous Outreach Navigator
- Hillary Dayne, Registered Dietician
- Christie Lackie, RN, COE
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