Submit online:
desjardinslifeinsurance.com/send
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:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

Desjardins Insurance
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: Stella Kioke-Kostachin | Certificate or identification no. | Social insurance no.*: —

Address of employee - No., street, apt.: P.O Box 152 | City: Attawapiskat | Province: ON | Postal code: P0L 1A0

Telephone no.: ( ) - | E-mail address:

POLICYHOLDER OR EMPLOYER Name: CINUP | Policy or group or contract no.: 641028 | Division no.:

Address of policyholder or employer - No., street, suite: 1805 E ARTHUR St., | City: Thunder Bay | Province: ON | Postal code: P7E 2R6

Telephone no.: (807) 622-1413 | Fax no.: ( ) -

COMPLETE IF SELF-ADMINISTERED: **Effective date of coverage:** (YYYY MM DD) **Class no.:**

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

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

1 Current salary — Amount: $2020.38
☐ Weekly ☐ Monthly ☒ Every two weeks

2 Salary effective date (YYYY MM DD): 2021 04 01

3 Job status: ☒ Full time ☐ Part time

4 Indicate days in normal work week: ☐ SUN ☒ MON ☒ TUE ☒ WED ☒ THU ☒ FRI ☐ SAT
Hours worked per week: 35

5 Type of schedule: ☐ Variable ☐ Rotating

6 Premium paid by: ☒ Employer ☐ Employee ☐ Both

7 Date of employment (YYYY MM DD): 2006 04 01

8 Occupation: Community Legal Worker

9 Date last worked (YYYY MM DD): 2021 10 05
No. of hours worked: 3.5

10 Is disability due to an accident? ☐ Yes ☒ No **If "Yes"**, date of accident:

11 Did or will the employee receive any income during the disability period? ☐ Yes ☒ No **If "Yes"**, indicate below:
(Type: holiday pay, maternity, disability, EI benefits, salary, lump sum, other)
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)? ☐ Yes ☒ No

13 Has a claim been filed with a government agency? ☐ Yes ☒ No **If "Yes"**, indicate below:
☐ CNESST / WCB / WSIB / WHSCC ☐ CPP / QPP ☐ SAAQ (Québec only)
☐ Other, specify:
Date Filed: (YYYY MM DD) **Decision Rendered:** **Amount:** $

14 Has the employee returned to work? ☐ Yes ☒ No **If "Yes"**, on what date? (YYYY MM DD)

15 Is this person still in your employ? ☒ Yes ☐ No - Termination date: (YYYY MM DD) Reason:

16 Was this person given a record of employment? ☐ Yes ☒ 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?
☒ No ☐ Yes - Please specify:

18 Is your employee eligible for an exemption under the Indian Act (R.S.C. (1985), c. I-5)? ☒ Yes ☐ No
If so, please indicate the percentage of employment income that is not taxable: 100 %

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		%	Duties		%
Duties	office administration	35 %	Duties	Customer service (take application) courts	35 %
Duties	travel to communities	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
☐ Outside	☐	☐	☐
☐ In extremes of cold or heat	☐	☐	☐

FREQUENCY:	O	F	A
☐ In a damp or humid environment	☐	☐	☐
☐ Toxic fume	☐	☐	☐

FREQUENCY:	O	F	A
☐ Above or below ground level	☐	☐	☐
☐ Handling chemicals	☐	☐	☐

Does the job involve other hazards? ☐ Yes ☑ No **If "Yes"**, please list:

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

FREQUENCY:	O	F	A
☐ Standing	☐	☑	☐
☐ Walking	☐	☑	☐
☐ Sitting	☐	☑	☐
☐ Keeping one's balance	☐	☑	☐

FREQUENCY:	O	F	A
☐ Bending over	☐	☐	☐
☐ Kneeling	☐	☐	☐
☐ Crouching	☐	☐	☐
☐ Crawling	☐	☐	☐

FREQUENCY:	O	F	A
☐ Extending/reaching above head	☐	☐	☐
☑ Climbing	☐	☑	☐
☑ Stairs (No. of steps 5)	☐	☑	☐
☐ Ladders (Height)	☐	☐	☐

DESCRIBE ACTIVITY AND SPECIFY FREQUENCY AND WEIGHT:	FREQUENCY: O	F	A	WEIGHT:
☐ Pushing	☐	☐	☐	☐ Lb ☐ Kg
☐ Pulling	☐	☐	☐	☐ Lb ☐ Kg
☑ Lifting/carrying	☐	☑	☐	☑ Lb ☐ Kg

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

Type of equipment	Times per day
Type of equipment	Times 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: travel by air, attend remote courts

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

If "Yes", please specify: travel, attending remote courts - sitting, standing, stairs

D - ADDITIONAL INFORMATION

SIGNATURE OF THE AUTHORIZED PERSON

Last name and first name of the authorized person (IN BLOCK LETTERS)
COLETTE SHWETZ

Position
HR MANAGER.

E-mail address
cshwetz@manlegal.on.ca.

Signature Colette Shwetz

Date Oct 13/21.

Direction and Authorization Form

DIRECTION AND AUTHORIZATION TO RELEASE PERSONAL INFORMATION

FROM [redacted]
Employee's (Claimant Name)

TO Desjardins Financial

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

INDIVIDUAL POLICY NUMBER : Select Policy Number

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 Financial) 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.

[redacted]
Signature of Claimant

October 12/21
Date

Employee Statement

Submit online:
desjardinslifeinsurance.com/send
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:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

Contact us: 1-800-263-1810 (toll free) or 416-926-2990

Desjardins
Insurance
Life • Health • Retirement

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: Kicker-Koostachin, Stella
Sex: ☐ M ☑ F
Date of birth (YYYY MM DD): 1966 08 12

Address - No., street, apt: Box 152
City: Attawapiskat
Province: On
Postal code: P0L 1A0

Policy or group or contract no: 641028
Division no:
Certificate or identification no:
Social insurance no[1]: 489 043 5288

Telephone no. (mandatory): (705) 997 2308
☑ I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me voicemail about my disability claim

E-mail address[2]: Stellakk_2001@yahoo.ca

[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

Level of education

Work experience

Spoken language: ☑ English ☐ French
Written language: ☑ English ☐ French

2. Is disability due to an accident? ☐ Yes ☑ No
If "Yes", date of accident (YYYY MM DD):
Time: ☐ AM ☐ PM
Type of accident: ☐ 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
Cortison Injections

4. Name, address and telephone number of physicians and specialists who have treated you during the disability
Dr. Robert Lafontaine
610 Ross Ave East
Timmins, ON P4N 2K3
(705) 360 5330

PLEASE COMPLETE THE BACK OF THE FORM.

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
N/A					$	☐ W ☐ M
					$	☐ W ☐ M

Comments

C - DIRECT DEPOSIT ENROLMENT

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.
Bank of Nova Scotia	002	11012	1820125

Address - No., street, suite	City	Province	Postal code
1 Pine Street South	Timmins	ON	P4N 2J5

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 October 7, 2021 The authorization will terminate following a 10-day written notice by either Desjardins Insurance or me

Signature of employee: [signature] **Date:** October 12/21

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 strictly 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 facilities, 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.

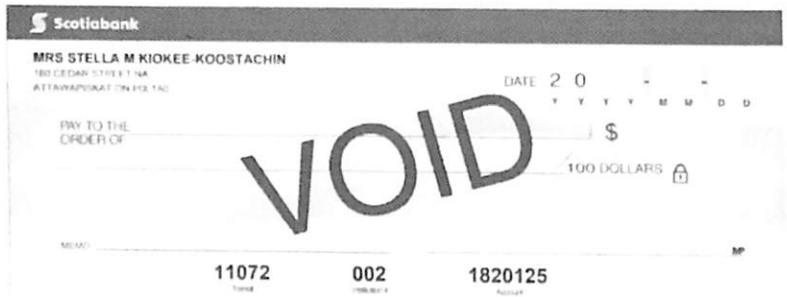
Signature of employee: [signature] **Date:** October 12/21

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.

Scotiabank®

Void Cheque



Attending Physician Statement

(Please take full package to your physician)

Desjardins
Insurance
Life • Health • Retirement

GROUP INSURANCE DISABILITY CLAIMS

Surgery Claim
07/10/2021

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 1-844-409-6571

Submit online

Complete and save the form on your computer first. Keep original forms for your records.

By mail

PO Box 1273 STN A
Toronto ON M5W 1G6
Send original forms and keep copies for your records.

By fax

1 844 479 6571 (toll free)
416 926 0987
Send original forms for your records.

Desjardins
Insurance
Life Health Retirement

INITIAL ATTENDING PHYSICIAN'S STATEMENT
MUSCULO-SKELETAL FORM

PART 1 - Identification of patient

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

2. Studies

3. Symptoms and signs

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

	Please specify location(s) and physical findings	Severe	Moderate	Mild	Absent
Pain		☐	☐	☐	☐
Deformity		☐	☐	☐	☐
Muscle spasm		☐	☐	☐	☐
Muscle atrophy		☐	☐	☐	☐
Loss of tendon reflexes		☐	☐	☐	☐
Sensory change		☐	☐	☐	☐
Motor deficit		☐	☐	☐	☐
Straight leg raising limitation		☐	☐	☐	☐
Range of motion limitation		☐	☐	☐	☐
Other (specify)*		☐	☐	☐	☐

*If arthritic condition: ☐ In remission ☐ Continuously active ☐ Stable ☐ Seasonally 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) 2021/10/07 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

off work x 6 months post op

		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
5.1	Stand ☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.2	Walk ☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.3	Walk on uneven surfaces ☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.4	Sit ☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.5	Drive ☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
5.6	This patient can lift/carry a maximum of: kgs	0	5	9	14	18	23	27	32	36	41+
	lbs	0	10	20	30	40	50	60	70	80	90+
5.7	☐ No restriction ☐ Repetitively, how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	☐ Occasionally, how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

5.8 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)

Climb ___ Bend ___ Squat ___ Kneel ___ Climb ___ Reach (above shoulders) ___ Reach (below shoulders) ___

6. Prognosis and return to work plans

6.1 Prognosis for recovery good

6.2 Expected date patient will return to their own occupation 6 months

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 months

6.5 Have return to work time lines been discussed with the patient? ☑ Yes ☐ No

6.6 Please elaborate on time frames and patient's response

7. Progress

7.1 Has patient: ☐ Recovered ☐ Improved ☑ Not improved ☐ Retrogressed

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?

Left total knee
replacement on the
07/10/2021

11. Identification of physician

11.1 Last name and first name (PLEASE PRINT): Montcalm, Robert | 11.2 Specialty: | License no.:

11.3 Address - No., street, suite: 646 Kiss Hill Last | City: Timmins | Province: ON | Postal code: P4N 0A2

11.4 Telephone no.: (705) 360-5330 | Fax no.: (705) 360-5313

Signature of physician: _____ | Date: 06/10/2021

Submit online:
desjardinslifeinsurance.com/send
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:
1-844-409-6571 (toll free)
416-926-0697
Keep original forms for your records.

Desjardins Insurance
Life · Health · Retirement

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
	641028		

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 treatment. _____

2.4 Is condition due to injury or sickness arising out of patient's employments? ☐ Yes ☐ No ☐ Unknown

2.5 Have Worker's Compensation/CSST forms been completed? ☐ Yes ☐ No ☐ Unknown

2.6 If patient is pregnant, give E.D.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 _____

3.2 Date of latest visit _____

3.3 Frequency of visits ☐ Weekly ☐ Monthly ☐ Other (specify) _____

3.4 Date of in-patient admission _____

3.5 Date of discharge _____

3.6 Date of out patient treatment _____

3.7 Name of hospital _____

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 ☐ House confined ☐ Bed confined ☐ Hospital confined

6. 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	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.2	Walk	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.3	Walk on uneven surfaces	☐ Yes ☐ No	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.4	Sit	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.5	Drive	☐ No restriction	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
6.6	This patient can lift/carry a maximum of	kgs	0	5	9	14	18	23	27	32	36	41+
		lbs	0	10	20	30	40	50	60	70	80	90+
6.7	☐ No restriction	☐ Repetitively, how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		☐ Occasionally, how much?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 shoulder) ____

7. Psychiatric illness (if applicable)

7.1 History _____
7.2 Precipitating chronological events _____
7.3 Work issue related to illness _____
7.4 Pre-morbid personality _____
7.5 Changes in ADL habits _____
7.6 Family/social factors _____
7.7 Progress with treatment plan _____
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

8. 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 timelines 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 vocational 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) Williams, Robert
11.2 Specialty Orthopedic License no 76[illegible]
11.3 Address (no., street, suite) [illegible] City Timmins Province ON Postal code P4N [illegible]
11.4 Telephone no. ([illegible] Fax no. (705) 360 5313
Signature of physician _____ Date _____