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		Certificate or identification no.	Social insurance no.*
Naveau	Shannon		501-603-757

Address of employee - No., street, apt.	City	Province	Postal code
45-630 Riverpark Rd	Timmins	Ontario	P4P 1B4

Telephone no.: (705) 288-9007 E-mail address:

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

Address of policyholder or employer - No., street, suite	City	Province	Postal code
1805 Arthur St	Thunder Bay	Ontario	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: $ 1,923.08
☐ Weekly ☐ Monthly ☑ Every two weeks

2 Salary effective date (YYYY MM DD): 2018-01-29

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: 35.00

5 Type of schedule: ☐ Variable ☑ Rotating

6 Premium paid by: ☑ Employer ☐ Employee ☐ Both

7 Date of employment (YYYY MM DD): 2018-01-29

8 Occupation: Gladue Case Worker

9 Date last worked (YYYY MM DD): 2022-07-15
No. of hours worked: 7.00

10 Is disability due to an accident? ☐ Yes ☑ No **If "Yes"**, date of accident: (YYYY MM DD)

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: Shannon works with clients in crisis and/or have been through trauma and have been incarcerated. Shannon will need to be able to work in this type of environment and be able to assist clients accordingly. She would need to be mentally and emotionally well to do her job.

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: 100.00 %

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	meet with clients and support in Gladue process	25 %	**Duties**	Refer clitnest to appropriate aftercare	25 %
Duties	Meet with clients to provide aftercare planning	25 %	**Duties**	Assist clients in court process, carry out recommenation	25 %

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 30)	☐	☑	☐
☐ 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	Photocopier	Times per day	3
Type of equipment	Personal Vehicle	Times per day	1

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: Employee works with a case load of files for clients, she carries out the sentencing recommentadations in case management for clients to recieve appropriate aftercare services, takes clients to medical, probation, and treatment appoirntments. See attached job description.

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

If "Yes", please specify: Employee is at desk and works with laptop entering casenotes onto the database.

D - ADDITIONAL INFORMATION

SIGNATURE OF THE AUTHORIZED PERSON

Colette Shwetz	HR Manager
Last name and first name of the authorized person (IN BLOCK LETTERS)	Position
cshwetz@nanlegal.on.ca	
E-mail address	
Colette Shwetz	July 24/22.
Signature	**Date**

Nishnawbe-Aski Legal Services Corporation

GLADUE CASE WORKER

Job Description

Title: Gladue Case Worker

Dept.: Gladue

Reports to: Gladue Team Leader

JD #: Gladue 0002

Approved: April 1, 2021

REVIEWED: April 1, 2021

Summary

The Gladue Caseworker is responsible for assisting aboriginal offenders in fulfilling the recommendations made in a Gladue report written on their behalf. The Gladue Caseworker will provide direct services, and make necessary referrals to programs and services in the community to ensure the clients receive services in a timely fashion. The Gladue Caseworker will work in partnership with the Gladue Writer, Courts and/or Probation and Parole Services in providing necessary client input and updates as required.

Core Competencies:

- Group facilitation, team building and decision making skills; ability to problem solve and take initiative.
- Self-motivated individual with the ability to work with minimal supervision in a team oriented setting.
- Effective crisis intervention skills.
- Proficiency in Microsoft Office including database applications.
- Ability to engage people to build trust and rapport; effective verbal and listening communication skills; excellent interviewing and counselling skills.
- Proficiency in Microsoft Office including database applications.
- Excellent case and file management skills, stress management and time management skills, ability to meet deadlines.

Job Duties

Program/Project Specific Management Work Duties

- Meet with clients to support them through the Gladue Report process.
- Work with the Gladue Writer in developing sentencing recommendations.
- Meet with clients to provide individual counselling and care plans.
- Advocate on behalf of and refer clients to appropriate services within the community.

- Meet with the client's family to facilitate the understanding and meeting the conditions the courtshave imposed.
- Provide recommendations and support to the family how they can support the client.
- Attend Court, specifically Bail Court to identify and advocate for clients who could benefit from aGladue Report or Letter either at the Bail stage or Sentencing.

Program Administration PAPER WORK

- Complete applications for treatment centres and coordinate travel.
- Provide follow-up services to chart client's progress.
- Prepare Gladue letters when appropriate.

Outreach and Promotion/Public Relations OUTSIDE RELATIONS

- Work with the Gladue Team Leader, Gladue Writer and any additional partners to the GladueServices program.
- Network with stakeholders, community agencies, participants, and families.
- Respond to general enquiries regarding the Gladue Services Program.

Relationships

Executive Director
The Gladue Caseworker will keep the Gladue Team Leader and LAO Area Director apprised of all important matters related to the Gladue Aftercare Program by providing written reports for review and oral reports on an ad hoc basis.

Gladue Services Program
The Gladue Caseworker will keep the Gladue Team Leader apprised of all important matters related to their projects and clients by providing written reports for review and oral reports on an ad hoc basis.

NAN Legal Staff
The Gladue Caseworker will work collaboratively with other NAN Legal staff by maintaining communication lines to allow opportunity to share information relevant to the program.

Requirements

- Preferred Community College diploma, University degree or equivalent in Social Services and/or a minimum of 5 years work in a social or justice services environment.
- Knowledge of the judicial system, Criminal Code, and other related federal and provincial statutes, and related court decisions regarding Aboriginal persons.
- Knowledge of Aboriginal culture and experience working with Aboriginal persons; understanding of the northern cultural environment; knowledge of an Aboriginal language(s) will be considered an asset.
- Experience in program delivery and administration.
- Ability to work flexible hours, including evenings and/or weekends.
- A clear criminal reference check (CPIC) and Vulnerable Sector Clearance will be a condition of employment
- Must have a valid Ontario driver's license and reliable transportation.

Reporting

- Under direction of the Gladue Team Leader the Gladue Caseworker is responsible for the coordination and administration of the Gladue Aftercare Program.
- The Gladue Caseworker is accountable to the Gladue Team Leader and LAO Area Director for the efficient performance of his/her function.

Meetings, Training and Outreach

- Participate in Gladue Aftercare Training as needed.
- Attend all meetings, telephone and video conferences, committees, as directed.
- Attend professional development, training, workshops, education, as directed.
- Develop positive relationships with justice providers, defense counsel, police authorities, community leadership, duty counsel, crown attorneys, probation, parole and more. Keep program coordinator, supervisor, manager, or director apprised.

File maintenance

- Ensure all paper and electronic files are maintained up-to-date.
- Follow directives, guidelines, and policies for records management and file keeping policies.

Additional Duties and Responsibilities

- Complete all additional responsibilities and duties as assigned.
- Other duties as assigned.

SALARY RANGE

Pursuant to current wage grid.

Temporary Added Duties

- Providing administrative support to the Gladue Manager and Gladue team.

CINUP
Employee Benefits for First Nations

EMPLOYEE DISABILITY CHECKLIST

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

- *Direction and Authorization Form*
- *Employee Statement*
- *Attending Physician's Statement (take full package to your attending physician who will complete the appropriate form)*
- *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 Shannon Naveau
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.

Shannon Naveau
Signature of Claimant

July 20, 2022
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		Sex	Date of birth (YYYY MM DD)
NAVEAU	SHANNON	☐ M ☑ F	1974 07 10

Address - No., street, apt.	City	Province	Postal code
45-630 Riverpark Rd	Timmins	Ontario	

Policy or group or contract no.	Division no.	Certificate or identification no.	Social insurance no.[1]
641028	59086	006346908	501603757

Telephone no. (mandatory): (705) 288-9007

☑ I authorize Desjardins Financial Security, hereinafter Desjardins Insurance, to leave me voicemail about my disability claim.

E-mail address[2]: snaveau@nanlegal.on.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: Post Secondary

Work experience: Administrative, Case Worker

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:

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

Dr. Steven Lax
Suite 201 227 Algonquin Blvd
Timmins ON P4N 2R8
705 264-8840

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
					$	☐ W ☐ M
					$	☐ W ☐ M

Comments: N/A

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.
TD Canada Trust	004	00259	6578351

Address - No., street, suite	City	Province	Postal code
6 Pine Street South	Timmins	Ontario	P4N 2J8

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: Shannon Dawson **Date:** July 20, 2022

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: Shannon Dawson **Date:** July 20, 2022

VERY IMPORTANT

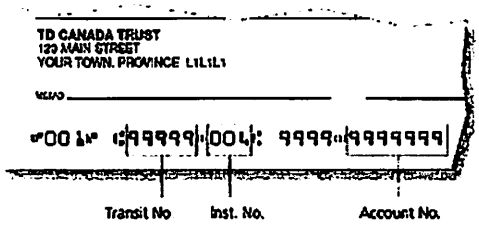
Please have the initial attending physician's statement completed and submit the completed forms online, or by mail or fax to: Desjardins Insurance – Disability Claims.

TD Canada Trust

Info Sheet

How to Set up Direct Deposits or Pre-Authorized Debits

3760
6 Pine Street South
TIMMINS, ONTARIO P4N 2J8



Customer Name

SHANNON LEE NAVEAU

Transit No.	Inst. No.	Account No.
00259	004	6578351

You can find your branch address information on your cheques or by using our branch locator tool:
www.tdcanadatrust.com/locator

Direct Deposit

Direct Deposit is the most convenient way to receive recurring deposits (i.e. pay, pension, government payments, annuity, interest, etc.) with immediate access to funds. There are no holds on your funds or a need for special trips to your local branch or ATM to deposit your cheques.

To set up a Direct Deposit with the federal government:

1. Visit **www.directdeposit.gc.ca** for a Government of Canada Direct Deposit enrolment form and use your account information from the fields above when completing the form.
2. If you do not have a cheque to void, have your local TD Canada Trust branch stamp the enrolment form.
3. Once complete, mail the enrolment form to the address provided.

Note: Additional information may be required on the form such as your Social Insurance Number or date of birth. The form includes a toll free number for support with completing the form.

To set up a Direct Deposit with your employer:

1. Provide your account information from the fields above to the payroll department of your employer or company pension provider.

Pre-Authorized Debit (PAD)

A Pre-Authorized Debit (PAD) is an automatic withdrawal taken directly from your TD Canada Trust account by a company or financial institution that you have authorized to do so. PAD is a great way for you to save time with bill payments (i.e. utilities, credit cards) you pay by mail, at the ATM, in branch or by phone; and may help you avoid late fees.

To set up a PAD:

1. Call or visit the website of the company you wish to set up a Pre-Authorized Debit (PAD) with to obtain a PAD Agreement and use your account information noted from the fields above when completing the Agreement.
2. If the company allows for online form submission on its website, you will need to first register for its website and should follow the instructions provided.

*Note: If your billing company accepts Visa Debit in Canada (or Visa internationally) and you have the enhanced **TD Access Card**, setting up a PAD will be easier than ever! Simply provide them with the card's 16 digit number in place of the account information noted above.*

Attending Physician Statement

(Please take full package to your physician)

Desjardins
Insurance
Life • Health • Retirement

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 1-844-409-6571

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 PSYCHIATRIC/PSYCHOLOGICAL FORM

(A) PLEASE PRINT.
(B) PART 1 to be completed by patient.
(C) PART 2 to be completed by physician.
(D) 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
NAUEAU, SHANNON	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 psychiatric/counsellor consultation reports for our review. Please include or indicate reasons for not including the requested information.

1. Diagnosis (please use DSM-IV criteria)

		Supporting data: Please describe the symptoms (severity and frequency), that support each axis of your diagnosis.
1.1	Axis I: Depression	Severe / constant
1.2	Axis II: Ø	N/A
1.3	Axis III: hypertension	tablets on RX lisinopril
1.4	Axis IV: family situational	loss of sister
1.5	Axis V - Current GAF score: 60	

2. History

2.1	When did symptoms start and/or worsen?	S.L ~~Sept~~ Aug-sept/2021
2.2	Date patient's condition first prevented them from working?	25/7/2022
2.3	Date of first visit for treatment or consultation:	06/07/2022
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 N/A	
2.7	Date of latest visit: July 20/2022	
2.8	Frequency of visits: ☐ Weekly ☐ Monthly ☑ Other: as required	
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:
3.2	If pending, is there an appointment date? ☐ Yes ☑ No	If yes, date : pending NO date provided yet
3.3	Is patient seeing or being referred to a therapist? ☑ Yes ☐ No	If yes, name of therapist: ~~Jessica~~ Louise Spence
3.4	Date of hospital inpatient admission: N/A	Date of discharge:
	Name of hospital:	

4. Precipitating 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/Motivation ☐ Other issues

Comments:

5. Current treatment

5.1 Therapy method: psychiatry / psychologist – pending

5.2 Therapy goal: to resolve depression/anxiety

5.3 Frequency and length of therapy/counselling sessions: as per S.I

5.4 Number of therapy/counselling sessions to date: None

5.5 Treatment compliance: full

5.6 Treatment response to date: too early to say

5.7 Prognosis and time frame of illness: prognosis is reasonable

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

Self med summary enclosed

6. Future treatment plans

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

covered above

7. Return to work plans

7.1 Prognosis for recovery: full recovery uncertain

7.2 Expected date patient will return to their own occupation: Sept 30/2022

7.3 If unknown, please indicate the next follow up date: TBD

7.4 If your patient is unable to return to their regular occupation, please specifywhen and under what circumstances they could return to work (eg. modified duties, gradual return to work.): N/A

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: too soon

7.7 Is your patient a suitable candidate for vocational rehabilitation? ☐ Yes ☑ No If yes, please specify: Not at present to disabled

7.8 When and under what circumstances could patient return to modified duties or a gradual return to work? when improvement in cognition / concentration and stamina noted

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? covered above

9. Identification of physician

9.1 Last name and first name (PLEASE PRINT): DR. STEVEN A. LAX

9.2 Specialty: CCFP

License no.: 51130

9.3 Address - No., street, suite: 201-227 ALGONQUIN BLVD.W. City: TIMMINS, ONT. Province: P4N 2R8 Postal code

9.4 Telephone no.: (705-264-6849 - Fax no.: ( ) -

Signature of physician:

Date: 20/07/22

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

A PLEASE PRINT.
B PART 1 to be completed by patient.
C PART 2 to be completed by physician.
D 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 this illness: _____
7.4 Pre-morbid personality: _____
7.5 Changes in ADL habits: _____
7.6 Familial risk 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 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:

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 MUSCULO-SKELETAL FORM

(A) PLEASE PRINT.
(B) PART 1 to be completed by patient.
(C) PART 2 to be completed by physician.
(D) 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

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	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): _____ 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
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):
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 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?

_____

_____

_____

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:**

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
CARDIAC FORM

A PLEASE PRINT.
B PART 1 to be completed by patient.
C PART 2 to be completed by physician.
D 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 Date symptoms 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 ☐ Psychophysiologic

☐ Other (please specify): _____

2.2 BP 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) EKG: _____ 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	☐ 1-10 (0.5 - 4.5 kg) ☐ 11-20 (5.0 - 9.1 kg) ☐ 21-50 (9.5 - 22.7 kg)	Frequency: _____ Duration: _____
Pushing/Pulling	☐ 1-10 (0.5 - 4.5 kg) ☐ 11-20 (5.0 - 9.1 kg) ☐ 21-50 (9.5 - 22.7 kg)	Frequency: _____ Duration: _____
Standing: _____ hours Walking: _____ blocks Driver's license revoked: ☐ Yes ☐ 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 behavioural disorder such as depression, anxiety, etc.

7.2 ☐ Exaggeration, 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 ☐ Retrogressed

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:**

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 CANCER FORM

(A) PLEASE PRINT.
(B) PART 1 to be completed by patient.
(C) PART 2 to be completed by physician.
(D) 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 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 dates 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 Specialty | License no.

8.3 Address - No., street, suite | City | Province | Postal code

8.4 Telephone no.: ( ) - | Fax no.: ( ) -

Signature of physician: | Date: