THE
Great-West Life
ASSURANCE COMPANY

Attending Physician's Statement

Short Term Disability Claim

The purpose of this Statement is to assist Great-West Life in making a decision on your patient's claim for disability benefits. YOUR PATIENT WOULD APPRECIATE THE COMPLETION OF THIS FORM AS SOON AS POSSIBLE. ***OTHERWISE, THERE MAY BE A DELAY IN THE PROCESSING OF THIS CLAIM. PLEASE KEEP A COPY FOR YOUR RECORDS.***

Plan Member/Employee Information and Consent (To be completed by patient)

Plan Member Name (last, first, middle initial)		Home Phone #	Cell Phone #
Address (Street, City, Province, Postal Code)			
Employer's Name **CANADIAN NATIONAL RAILWAYS**		Plan contract number **51978**	PIN number
Height	Weight	Date of Birth (dd/mm/yyyy)	

I authorize my healthcare or rehabilitation provider to disclose my personal information, including my medical and health information and including consultation reports, to Great-West Life for the purpose of investigating and assessing my claim(s), administering coverage(s) that I may have with Great-West Life and administering the group benefits plan.

I acknowledge that the personal information is needed by Great-West Life for the purposes stated above. I acknowledge that my consent enables Great-West Life to process my claim(s) and refusing to consent may result in delay or denial of my claim(s).

This consent may be revoked by me at any time by sending a written instruction.

I confirm that a photocopy or electronic copy of this authorization shall be as valid as the original.

_____ _____

Plan Member's signature Date (dd/mm/yyyy)

I hereby authorize Great-West, and any successor, to release this form, all reports and test results provided to Great-West Life in relation with this claim to CN Occupational Health Services (or its delegate) when relevant for the purpose of their determination of my fitness to return to work, as well as to assist with the assessment of my claim(s).
I understand that I am responsible for any fees related to the completion of this form.

_____ _____

Plan Member's signature Date (dd/mm/yyyy)

Attending Physician's Statement

Diagnosis(es):	If Childbirth: Expected or Actual Delivery Date ☐ Vaginal ☐ C-Section
Is condition arising from employment? ☐ Yes ☐ No	
Date of First Visit for Current Condition (dd/mm/yyyy)	First Date of Work Absence due to Condition (dd/mm/yyyy)
Frequency of Visits ☐ Weekly ☐ Monthly ☐ Other _____	
Hospitalized? ☐ Yes ☐ No Name of Institution:	Date Admitted (dd/mm/yyyy): _____ Date Discharged (dd/mm/yyyy): _____
Treatment (drug dosage, physiotherapy, other):	
Describe current symptoms, severity and frequency and duration of each symptom:	
Describe clinical findings (i.e.: range of motion, tenderness, swelling, etc.):	

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Please attach copies of all relevant:
- **Chart notes**
- **Test results/investigations (if test results are not attached, we will interpret this as tests were not performed)**
- **Consultation reports**

NOTE TO PHYSICIAN
- **If your patient has returned to work or will return to work within 6 weeks of the Last Date Worked, please indicate the date of return and proceed to end of form: Physician's Acknowledgement and Authorization.**
- **If not, please complete the entire form.**

Continuation of Attending Physician's Statement for Absences that may be Greater than 6 Weeks

Has the patient been treated for this condition in the past? ☐ Yes ☐ No If yes, date (dd/mm/yyyy): _____

Is drug or alcohol abuse impacting your patient's level of function? If so, please explain and advise if a referral to a treatment program has been initiated. Provide date, duration, frequency (day treatment or in-house program), and name of facility used for all current and any past alcohol/drug treatment.

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

Name of Specialist _____ Specialty _____ Date of Visit _____

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

Based on your findings and clinical observations, please describe your patient's current cognitive restrictions and limitations.

If your patient is absent from work due to a physical disability, please indicate your patient's current physical abilities:

☐ Sedentary Duties: require mainly sitting, occasional walking and standing, and possible lifting of 5 kg or less.

☐ Light Duties: require 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: require 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: require frequent handling of loads up to 23 kg, sometimes up to 45 kg.

List physical restrictions and tolerances: _____

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

Year _____ Month _____ Day _____

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

Year _____ Month _____ Day _____

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

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

Physician's Authorization

_____ _____
Attending Physician (please print) Certified Specialist

_____
Address (number, street, city, province, postal code)

( ) _____ ( ) _____
Telephone number (include area code) Fax number (include area code)

_____ _____
Signature Date signed (dd/mm/yyyy)

NOTE: THE PATIENT IS RESPONSIBLE FOR ANY FEES INCURRED FOR THE COMPLETION OF THIS FORM.