ATTENDING PHYSICIAN'S STATEMENT - SHORT TERM DISABILITY CLAIM

Throughout this form "Empire Life" refers to The Empire Life Insurance Company.

Reset Form

Employee Information and Consent - TO BE COMPLETED BY THE PATIENT

Name of Employee (first, middle, last)				
Address (street, number)		City	Province	Postal code
◯ Male ◯ Female	Height	Weight	Date of birth (dd/mmm/yy)	Phone number
Name of Employer				

I hereby authorize the release of medical and health information in my file to Empire Life and/or its authorized agents for the purpose of assessing my disability under my employer's short-term disability plan. This medical and health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results and hospital records.

I understand that I can revoke this consent at any time but that without it my claim cannot be assessed.

I understand that I am responsible for any fees related to the completion of this form.

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

Medical and health information excludes genetic test results.

Employee signature X	Date (dd/mmm/yy)

The patient is responsible for any fees related to the completion of this form.

Attending Physician's Statement - TO BE COMPLETED BY THE PHYSICIAN

- If your patient has returned or is expected to return to work within 4 weeks of the last date worked, complete **page 1 only** and sign the end of the form.
- For absences expected to be greater than 4 weeks, please complete **pages 1 and 2 in full**.

Primary diagnosis:

Secondary diagnosis and/or complications:

If childbirth - expected or actual delivery date (dd/mmm/yy)	Occupational illness/injury ◯ yes ◯ no If yes - date of illness/injury:	Auto accident ◯ yes ◯ no If yes - date of accident

Date of first visit to you pertaining to this condition (dd/mmm/yy)	First date of work absence due to this condition (dd/mmm/yy)

Has the patient ◯ been hospitalized or ◯ had day surgery for this condition?

Institution name	Date of admittance (dd/mmm/yy)	Date of discharge (dd/mmm/yy)

If surgery was performed, specify date (dd/mmm/yy) _____ and provide a description of the surgery:

Treatment (drug, dosage, physiotherapy, psychotherapy, etc.)

Prognosis - please provide the prognosis for recovery:

Expected return to work date (dd/mmm/yy):

Empire Life

Continuation of Attending Physician's Statement - FOR ABSENCES THAT MAY BE GREATER THAN 4 WEEKS

Has the patient been treated for this same or a similar condition in the past? ◯ yes ◯ no — if yes, please state when and describe:

Please describe the patient's current symptoms including history, severity and frequency:

Frequency of visits ◯ weekly ◯ monthly ◯ other _____

Has the patient been advised to have any surgery, tests or consultations not yet completed? ◯ yes ◯ no - if yes, provide details below:

Please attach copies of all relevent consultation reports and test results/investigations, including physiotherapy reports.
If test results are not attached, we will interpret this as tests were not performed.

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations:

Please list any complications/additional conditions impacting your patient's level of function or the typical recovery period:

Is the patient following the recommended treatment program? ◯ yes ◯ no

Do you have concerns about the patient's ability to manage his/her own affairs? ◯ yes ◯ no

Please provide comments and further details you feel would be helpful:

Notice to Physician:
The information in this statement will be kept in a life, health or disability file with Empire Life on behalf of the patient's employer and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

Name of Attending Physician (please print)		Certified specialty	Physician's stamp
Address (street, city, province, postal code)			
Telephone number	Fax number	Email address	
Attending Physician's signature **X**		Date (dd/mmm/yy)	

Please send this completed form to:
Email: sherwinwilliamsclaims@empire.ca
Fax: 1-855-430-9455

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