

ATTENDING PHYSICIAN STATEMENT (APS)

Absence Exceeding 4 Days in Duration

The employer is committed to ensuring employees who are unable to perform their regular job duties due to a medical condition are provided with support including time off work, access to Short Term Disability (STD) benefits and a safe, timely return to work program. In order for an absence of more than 4 days to qualify for benefits under the employer's STD plan, the plan member must provide objective evidence of an impairment severe enough to prevent them from performing their regular job duties.

- STD benefits will not be paid unless and until all requested documentation has been reviewed, and the claim approved. This is not a request for examination, but for information taken from your physician's chart.
- If absence is related to surgery this form is to be completed after the surgery has been done.

1 Claim Details

To be completed by the Plan Member

Employer Name:			
First Name of Plan Member		Last Name of Plan Member	
Plan Member's Employee Number	Date of Birth (dd/mm/yyyy)	Home Telephone	Work Telephone
Cellphone Number		E-mail Address	
Home Address		Occupation	
Please describe the nature of illness or injuries sustained:			
Is your illness or injury due to an accident <input type="checkbox"/> Yes <input type="checkbox"/> No			
<u>If Yes</u>			
1) Did the accident happen at <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Elsewhere Date and Time of accident (dd/mm/yyyy) _____ at _____ am/pm			
2) Have you or will you be applying for Workers' Compensation/CSST? <input type="checkbox"/> Yes <input type="checkbox"/> No			
3) Is your illness or injury due to a motor vehicle accident <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, enclose a copy of the accident report.			
4) 1 st Day of Work Missed due to this illness or injury _____			
When did you first seek medical attention for this illness/injury (dd/mm/yyyy)		Date you returned to work or expect to return to work (dd/mm/yyyy)	
Disability Type: <input type="checkbox"/> Illness <input type="checkbox"/> Non-Work Injury <input type="checkbox"/> Work Injury <input type="checkbox"/> Motor Vehicle Accident <input type="checkbox"/> Other Condition			

2 Authorization to Release Information

To be completed by the Plan Member

<p>I certify that the information provided above is true and complete.</p> <p>I understand that it is my obligation to obtain the certification of a physician to support this claim. Failure to provide the appropriate medical information may result in a delay or denial of short term disability benefits.</p> <p>I authorize my health care provider to complete and provide the mandatory information in Section 3, being those items not marked with an asterisk. At the initial stage of a claim, only this information is required.</p> <p>I understand the information in Section 3 marked with an asterisk is optional but may be required depending on the nature and/or extent of the claim. I understand that I can provide that information now if I choose by initialling those items with an asterisk indicating that my health care provider is authorized to complete and provide those items.</p> <p>Employee Signature: _____ Date: _____</p>

3 Physician Questionnaire Continued

Note that modified work is available to accommodate most common limitations and restrictions

4) Functional Capacity – IF AND TO THE EXTENT APPLICABLE TO THE CURRENT ABSENCE PLEASE COMPLETE BELOW

If the employee's job were temporarily modified could this employee return to work Yes No

PLEASE COMPLETE WHERE LIMITATIONS ARE RECOMMENDED ESTIMATED DURATION _____
 Occasional 0-33% Frequent 34-66% No Limitations
 Comments Distance
 Height frequency
 Body part affected

A. SITTING / STANDING / WALKING

Sitting / Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Continuous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending/Twisting			

B. LIFTING FLOOR TO WAIST

Sedentary (up to 4.5 kgs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light (4.6 – 9.0 kgs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medium (9.1-22 kgs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C. LIFTING WAIST TO SHOULDER

Sedentary (up to 4.5 kgs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Light (4.6 – 9.0 kgs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medium (9.1-22 kgs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. COGNITIVE CAPABILITIES

Verbal Communication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attention to Detail	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to follow and provide instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Able to operate motor vehicle Yes No

Respond to MOT Yes No

Date: _____

To the best of my knowledge, I estimate this employee will be total disabled from

Date: _____ to Date: _____
 (dd/mm/yyyy) (dd/mm/yyyy)

* Are there any psychological stressors (Axis JV) that may affect return to work? Please check and indicate Functional Limitations

Problems related to the social environment _____ Other psychological and environmental problems _____
 Problems with access to health care services _____ Workplace issues _____

5) Prognosis

a) What is the prognosis for return to regular unrestricted work? _____

b) What are the factors affecting your patient's prognosis? _____

Is complete recovery expected? Yes No

Notice to Physician

Any information provided by me regarding this absence may be disclosed to the employee and / or those authorized by him/her to receive such disclosure unless you notify us in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the employee or result in harm to a third party.

 Physician Signature

 Date (dd/mm/yyyy)

 Physician Name

 Street

 City Province Postal Code

 Telephone number:

 Fax Number: