

the
benefits trust

Employee Information

Please inform The Benefits Trust as soon as you return to work.

Employer Information

BT0 9-AS- A

INFORMATION MUST BE COMPLETE OR CLAIM WILL NOT BE PROCESSED

Attending Physician's Statement

1. Patient's name: _____ Date of Birth: (M) _____ (D) _____ (Y) _____
2. Diagnosis and Symptomatology (Accurate diagnosis required to cause "total" or "partial" disability, and complications if any).

3. Is this a Workplace Safety & Insurance Board case? Yes ☐ No ☐
4. a) Is the patient pregnant? Yes ☐ No ☐
b) Is pregnancy the cause of this disability? Yes ☐ No ☐ If yes, please clarify below in item 10.
c) Expected date of delivery: (M) _____ (D) _____ (Y) _____
5. Name of Hospital (if patient was hospitalized): _____ Date of hospitalization: (M) _____ (D) _____ (Y) _____
_____ Date of discharge: (M) _____ (D) _____ (Y) _____
6. If patient was referred to you, name of referring physician: _____
7. Dates of all office visits and procedure(s) performed:
Date: (M) _____ (D) _____ (Y) _____ Date: _____ Procedure: _____
(M) _____ (D) _____ (Y) _____ Procedure: _____
Anticipated physiotherapy: Yes ☐ No ☐
8. a) Date of first consultation with present condition: (M) _____ (D) _____ (Y) _____
b) Date of first symptoms of this condition: (M) _____ (D) _____ (Y) _____
c) Follow up appointment date: (M) _____ (D) _____ (Y) _____
9. a) This patient was totally disabled from: (M) _____ (D) _____ (Y) _____ to: (M) _____ (D) _____ (Y) _____
b) If still disabled, indicate approximate date of return to work: (M) _____ (D) _____ (Y) _____
(Must be specific date – may be changed later)
c) If disability is not total, indicate date on which partial disability began: (M) _____ (D) _____ (Y) _____
(Please try to assess whether this illness or injury is severe enough to cause **total or partial** disability from employee's present job)
10. Comments: _____

Physician Signature: _____ Date: (M) _____ (D) _____ (Y) _____

Name (please print): _____ T e l e p h o n e: _____

Address: _____

City: _____ P r o v i n c e: _____ Postal Code: _____

IF THERE IS A CHARGE FOR COMPLETING THIS FORM, IT IS THE PATIENT'S RESPONSIBILITY