

**CERTIFICATION OF DISABILITY**

**PART I - TO BE COMPLETED BY EMPLOYEE**

I have made application for temporary disability benefits under the Short Term Disability provisions of the Plan. In support of the application, I hereby request my attending physician to release to the Trustees of the CSI-Canada Insurance Plan or to Manulife Financial any pertinent information in my file and/or records, including the information below.

Name: \_\_\_\_\_ Physician's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Address: \_\_\_\_\_  
 \_\_\_\_\_  
 Home Telephone No: \_\_\_\_\_ Telephone No: \_\_\_\_\_  
 E-mail address \_\_\_\_\_ Fax No: \_\_\_\_\_  
 Signed: \_\_\_\_\_ Date: \_\_\_\_\_ 20\_\_\_\_

**PART II - TO BE COMPLETED BY ATTENDING PHYSICIAN**

The above named participant in the CSI-Canada Insurance Plan has made application for temporary disability benefits. In order to process the application, please furnish the following information:

1. Diagnosis (complications if any) \_\_\_\_\_
2. If psychiatric diagnosis, DSM AXIS I: \_\_\_\_\_ GAF Score: \_\_\_\_\_
3. Prognosis and Treatment: \_\_\_\_\_  
\_\_\_\_\_
4. Medications \_\_\_\_\_ Dosage: \_\_\_\_\_ Date Started: \_\_\_\_\_
5. Date of first examination: \_\_\_\_\_ Date of most recent exam: \_\_\_\_\_  
Frequency of visits: \_\_\_\_\_
6. Objective findings/Results pertinent to Diagnosis (i.e. vital signs, urine testing, physical examination findings etc.)  
\_\_\_\_\_
7. Has the patient been referred to a specialist  Yes  No Specialist Name \_\_\_\_\_
8. If admitted to a hospital provide date admitted \_\_\_\_\_ Date discharged \_\_\_\_\_
9. Surgery: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_
10. If disability is due to pregnancy, expected delivery date: \_\_\_\_\_
11. Date work had to be discontinued due to this disability: \_\_\_\_\_
12. **Physical Limitations:**

<i>Walking:</i>	<input type="checkbox"/> short distances	<input type="checkbox"/> medium distances	<input type="checkbox"/> as tolerated
<i>Standing</i>	<input type="checkbox"/> < than 15 min	<input type="checkbox"/> < than 30 min	<input type="checkbox"/> as tolerated
<i>Sitting:</i>	<input type="checkbox"/> < than 30 min	<input type="checkbox"/> < than 1 hr.	<input type="checkbox"/> as tolerated
<i>Lifting floor to waist:</i>	<input type="checkbox"/> <10kg	<input type="checkbox"/> <25 kg	<input type="checkbox"/> as tolerated
<i>Lifting waist to shoulder:</i>	<input type="checkbox"/> <10kg	<input type="checkbox"/> <25 kg	<input type="checkbox"/> as tolerated
<i>Stair climbing:</i>	<input type="checkbox"/> none	<input type="checkbox"/> 2-3 steps	<input type="checkbox"/> short flight
<i>Ladder climbing:</i>	<input type="checkbox"/> none	<input type="checkbox"/> 2-3 steps	<input type="checkbox"/> 4-6 steps

“more”

Hand/Wrist movement:  gripping  typing  writing  
 twisting  partially reduced  as tolerated

Above shoulder activity: \_\_\_\_\_

Below shoulder activity: \_\_\_\_\_

Vision  acuity \_\_\_\_\_  depth \_\_\_\_\_  perception \_\_\_\_\_

Other: \_\_\_\_\_

**Cognitive/Mental Limitations:**

Attention and Concentration:  mild  moderate  severe

Learning and Memory:  mild  moderate  severe

Decision Making:  mild  moderate  severe

Judgement:  mild  moderate  severe

Organization and Planning:  mild  moderate  severe

Social interaction:  mild  moderate  severe

Communication:  mild  moderate  severe

Adaptation:  mild  moderate  severe

Other: \_\_\_\_\_

13. Expected length of this disability: \_\_\_\_\_

14. Are there any medical contraindications that would preclude the employee from performing regular duties at this time:  Yes  No If yes, please elaborate: \_\_\_\_\_

Are there any medical contraindications that would preclude the employee from performing modified duties within the restrictions and limitations noted above:  Yes  No If yes, please elaborate: \_\_\_\_\_

Are there any workplace accommodations that would facilitate an early return to work: \_\_\_\_\_

15. Date participant is expected to be able to return to work:  
Part time (50% or less of regular schedule): \_\_\_\_\_ 20\_\_\_\_  
Part time (More than 50% of regular schedule): \_\_\_\_\_ 20\_\_\_\_  
Full time (regular schedule): \_\_\_\_\_ 20\_\_\_\_

16. Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Physician's Name: \_\_\_\_\_ Signed: \_\_\_\_\_

*Please Type or Print*

*Signature of Attending Physician*

Date Signed: \_\_\_\_\_, 20\_\_\_\_

**PLEASE RETURN PROMPTLY**

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