acclaim
ABILITY MANAGEMENT INC.

Christian Education
HEALTH PLAN

Attending Physician Statement Form

(Please print clearly in ink)

SECTION 1: TO BE COMPLETED BY EMPLOYEE

Employee's Name_____ Phone No._____
(Last name first, in full)

Address_____|__|__|__|__|__|__|
(Street Number and Name) (Apt. No.) (City/Town) (Province) (Postal Code)

Date of Birth: |__|__|__|__|__|__|__|__| Language: ___ E ___ F ___ Sex: ___ M ___ F
Day Month Year

Are you claiming or receiving any other disability, wage loss and/or retirement benefits (e.g. WSIB, CPP/QPP, auto insurance, other)? ___Yes ____No
Are you working or volunteering in any capacity? ___Yes ___ No
Are you receiving wages from any source? ___Yes ___ No
Are you attending any educational course, program or institution? ___Yes ___ No

If yes to any of the above, please provide details of these items on a separate page and include any confirming documents, claim numbers, etc. If an accident caused your disability, indicate date |__|__|__|__|__|__|__|__|
WHERE and WHAT happened:

_____
_____

AUTHORIZATION

I do hereby authorize any healthcare provider, licensed physician, medical practitioner, hospital, clinic to disclose my medical and health information to Acclaim, which includes any independent evaluators, agents and consultants acting on behalf of Acclaim and disclose to Christian Education Health Plan. This consent pertains to my current absence from work and/or my need for modified or accommodated work, and/or the current referral to Acclaim for services. These services may include the results of consultations or assessments obtained regarding my health condition.

I understand that the aforementioned communication and information, portions thereof, and/or resulting recommendations that relate to my abilities or limitations to perform my job duties (excluding specific reference to diagnosis or related personal information) may be communicated to Christian Education Health Plan for the purposes of any one or more of the following:

1. Accommodating for my health condition with Christian Education Health Plan
2. Providing information for modified work with Christian Education Health Plan
3. Validating or authorizing an absence from work
4. Determining my eligibility for benefits; and/or
5. Managing my return to work with Christian Education Health Plan

By signing below, I consent to collection, use and disclosure of my personal information, including my health information, for the purposes as described above. I am aware that I can choose to provide or withhold this consent, but that may affect my eligibility for benefits through Christian Education Health Plan's Short Term Disability Benefits plan. In addition, I authorize Acclaim to release information to Christian Education Health Plan's LTD carrier, Manulife, in the event I transition to LTD benefits. I further authorize Acclaim to use and exchange with The Trustees of the Christian Education Health Plan any information needed for the purpose of the plan administration, claim assessment, audit, investigation and management of my claim.

This consent is valid from the date signed until I return to full hours and duties at work, or on the date my business relationship with Christian Education Health Plan has been formally severed, whichever is earlier. It may be withdrawn at any time if I provide prior written notification to Acclaim or to Christian Education Health Plan. A photocopy or facsimile of this authorization shall be as valid as the original.

_____ _____ _____
Employee Name (Printed) Employee Signature Date

SECTION 2: TO BE COMPLETED BY ATTENDING PHYSICIAN

Nature of Current Condition

1. Primary_____Signs/Symptoms_____

2. Secondary_____Signs/Symptoms_____

3. Contributing factors/complications:

_____

_____

4. Is this injury or illness directly caused by a workplace incident? __Yes ___No If yes, date of incident:_____

5. If disability is related to pregnancy, please indicate the expected date of delivery |__|__|__|__|__|__|__|__|
Day Month Year

History

1. Date symptoms first appeared |__|__|__|__|__|__|__|__|
2. Date of first visit since patient stopped work |__|__|__|__|__|__|__|__|
3. Date illness or injury forced cessation of work |__|__|__|__|__|__|__|__|
4. Date patient deemed totally disabled |__|__|__|__|__|__|__|__|
5. I see the patient every _____ (day, week, etc.)
6. Date of most recent examination |__|__|__|__|__|__|__|__
7. Has patient ever had a similar condition? ___ Yes ___ No If yes, state when and describe:

_____

_____

Treatment

1. If diagnostic studies were done, please indicate:
   Type_____ Date(s)_____ Result(s)_____
   Type_____ Date(s)_____ Result(s)_____

2. Are any further investigations planned? ___Yes ___No (If yes, please state date and type).

_____

_____

3. Names of other physicians involved with this patient's care during this period_____

4. If hospitalized, name of the hospital/institution_____
from |__|__|__|__|__|__|__|__| to |__|__|__|__|__|__|__|__|
Day Month Year Day Month Year

5. Surgery? ___ Yes ___ No (If yes, state surgical procedure). _____
Date of Surgery |__|__|__|__|__|__|__|__| ___ Performed ___ Planned Anesthetic: ___ Local ___ General
Day Month Year

6. List medications currently prescribed and dosage: _____

_____

7. Therapy? ___ Yes ___ No If yes, indicate type (e.g. physiotherapy, psychotherapy, etc.)_____
Freq: __Daily ___x per week _____ Location: __ Outpatient __ Therapist's Office __ Physician's Office___

8. Summary of patient's response to treatment:

_____

_____

Prognosis

1. Have you discussed a Return to Work Plan with your patient? ___Yes ___ No If no, why not?

_____

If yes, please provide details about the Return to Work Plan including recommendations for modified hours and/or modified duties:

_____

_____

Expected date of Return to Work Full-Time |__|__|__|__|__|__|__|__|
Day Month Year

Clinical Findings/Investigations

1. What functional limitations affect the patient's ability to perform his/her normal activities, including work?

FUNCTIONAL ABILTIIES:

Walking (continuously): □ up to 20 min; □ up to 1 hour; □ no restriction; □ Other (e.g. uneven ground) _____

Standing (continuously): □ up to 20 min; □ up to 1 hour; □ no restriction; □ Other _____

Sitting (continuously): □ up to 30 min; □ up to 1 hour; □ no restriction; □ Other _____

Lifting floor to waist: □ up to 20 lbs; □ up to 30 lbs □ up to 40 lbs; □ no restriction; □ other _____

Lifting waist to shoulder: □ up to 20 lbs; □ up to 30 lbs □ up to 40 lbs; □ no restriction; □ other _____

Pushing/Pulling: □ up to 10 lbs; □ up to 20 lbs □ up to 30 lbs; □ no restriction; □ other _____

Driving restrictions □ up to 30 min; □ up to 1 hour; □ no restriction; □ Other_____ Reported to Ministry of Transportation? □ Yes □ No

Stair/Ladder climbing: □ unable □ 2 – 3 steps only; □ own pace □ assisted □ no restriction

Employee is: □ Left handed □ Right handed □ Ambidextrous

Limited ability to used **left** hand to: □ hold objects; □ grip; □ type; □ write

Limited ability to used **right** hand to: □ hold objects; □ grip; □ type; □ write

Completely unable to use **left** hand to: □ hold objects; □ grip; □ type; □ write

Completely unable to use **right** hand to: □ hold objects; □ grip; □ type; □ write

Hours per day: □ 4 hours □ 6 hours` □ 8 hours □ 10 hours □ 12 hours □ no restriction

COGNITIVE ABILITIES:

Self Supervision:	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Supervision Exercised:	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Deadline Pressures:	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Attention to Detail:	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Exposure to Environmental Stimuli:	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Working in Cooperation with Others:	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Exposure to Confrontation	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Responsibility/Accountability	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Orientation:	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Attention:	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Memory:	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Goal Setting	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Planning	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Organization	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Reasoning	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Problem Solving	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Insight/Self Awareness	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Generalizing	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Language	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Calculation	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____
Time Management	□ limited capacity	□unable to perform	□ no restriction;	□ Other _____

NOTICE TO PHYSICIAN: Any information provided by you to ***Acclaim Ability Management*** regarding this claim may be disclosed to the claimant 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 claimant or in harm to a third party.

Physician's Name: _____ Phone No.: _____ Fax: _____
(Please print)

Address_____|__|__|__|__|__|__|
Street No. and Name Suite No. City/TownProvince Postal Code

Physician's Signature: _____ **Specialty**_____ **Date** |__|__|__|__|__|__|__|__|

Please fax completed form directly to ***Acclaim Ability Management***. at 1(866) 486-8663