CANADA POST / POSTES CANADA

Attending Physician's Statement

Short-Term Disability Claim

Please complete this form as soon as possible with all relevant and pertinent information to expedite the processing of your patient's claim for disability benefits under the Canada Post Short-Term Disability Program. **It should be completed and returned within 7 calender days from the onset of the disability to avoid interruptions of payment to the employee.** The completed form should be mailed or faxed directly to:

MORNEAU SHEPELL
50 BURNHAMTHORPE RD W SUITE 316
MISSISSAUGA ON L5B 3C2
Fax: 1-877-562-9126

This form is not to be used for workplace injuries/illnesses.

SECTION A To be completed by patient (please print)

Employee Name (Last, First, Middle initial):		
Employee ID number:	Email:	
Home phone number:	Alternate phone number:	
Address (number, street, city, province, postal code):		
Date of Birth (dd/mm/yyyy):	Bargaining Agent (if applicable):	Date form provided to physician (dd/mm/yyyy):

I hereby authorize the release of information held in my file by the physician named below to Great-West/Morneau Shepell and its agents and service providers for the purpose of assessing my claim and administering the disability plan regarding this claim. This medical information includes, but is not limited to, copies of consultation reports, clinical notes, test results and hospital records supporting this claim. **I understand that I am responsible for any costs related to the completion of this form.**

Employee's signature: Date (dd/mm/yyyy):

SECTION B To be completed by the attending physician or health care professional (please print)

Diagnosis(es) or working diagnosis(es): If psychological, please provide DSM IV Axis 1 diagnosis and GAF score. GAF score (if applicable):	Primary Diagnosis: Secondary Diagnosis:	If childbirth, expected or actual delivery date (dd/mm/yyyy):

Is the diagnosed disability the result of: ☐ a non-occupational illness? ☐ a non-occupational accident?

Has the patient had a similar or related condition? ☐ **No** ☐ **Yes** If yes, state when and describe condition:

Is the condition considered to be chronic? ☐ **No** ☐ **Yes** If yes, what precipitated the absence from work?

Date of first visit for current disability (dd/mm/yyyy): Date of last visit for current disability (dd/mm/yyyy):	Date first unable to work due to current disability (dd/mm/yyyy): Expected date of return to work (dd/mm/yyyy):
Admitted to hospital (inpatient or outpatient)? ☐ **No** ☐ **Yes** Date admitted (dd/mm/yyyy):	Name of institution: Hospital department/ward admitted to: Date discharged (dd/mm/yyyy):

Treatment (current medication, types of drug(s), dosage and duration, physiotherapy, other):

SECTION C Physician's acknowledgement and authorization (please print)

I acknowledge that the information in this statement will be kept in a health file with Great West/Morneau Shepell and may be accessed by the patient or third parties to whom access has been granted or those authorized by law. By providing the information, I consent to such unedited release of any information contained herein.

Address (number, street, city, province, postal code):	Telephone number: Fax number:
Signature:	Date signed (dd/mm/yyyy):

NOTE TO PHYSICIAN / HEALTHCARE PROFESSIONAL: If the disability is anticipated to be resolved within two weeks of its onset, no further information is required. If not, please complete section D.