

ATTENDING PHYSICIAN'S STATEMENT

(R2021-04)

For Sickness & Accident (S&A) Benefits Only (For Long Term Disability Income Benefits Application go to <u>www.canadalife.com</u>)

Instructions for Form Completion

Employee

- This form is for the sole purpose of applying for S&A benefits for absences greater than 5 days.
- Fully complete the top section of the form (please print).
- Review, sign and date the Authorization to Release Information.
- If your absence is, or is expected to be, greater than 5 working days, take the form with the top section filled in, or email it to your doctor for completion. (<u>Note</u>: forms completed after your illness/injury has resolved may not be approved for S&A benefits).
- <u>To avoid delay in benefit payment</u>, ask your doctor, or his/her receptionist, to <u>fax or email</u> this form to Homewood Health (The City of Calgary's health service provider) at 1-866-460-4645 or <u>DisabilityManagement@HomewoodHealth.com</u>.
- It is your responsibility to maintain regular contact with your supervisor during your absence and to notify your supervisor **prior** to returning to work. For Transit Operators: You must call VP Dispatch prior to 1500 hours the day prior to returning to work full duties. Should you require an accommodation, you must contact VP Dispatch as soon as possible in order to make appropriate arrangements.
- In order to protect the confidentiality of medical information, DO NOT give this form to your supervisor or other City of Calgary representative(s). Homewood Health will inform your supervisor and Pay Services of the status of your claim.
- A representative from Homewood Health may contact you to clarify information or to request subsequent information.
- You are responsible for any costs associated with the completion of this form not covered by your benefit plan.
- If you have questions please call HR Support Services at 403-268-5800 or Homewood Health at 403-705-2024.

Attending Physician

- As this form is used to determine eligibility for disability benefits and to assist the accommodation of ill/injured employees back into the workplace, **please complete the form with as much detail as possible**. Any delay in form completion may result in interruption or delay of the employee's pay.
- Please <u>fax or email</u> the completed form immediately to Homewood Health (The City of Calgary's health service provider) at **1-866-460-4645** or <u>DisabilityManagement@HomewoodHealth.com</u>.
- A representative or physician from Homewood Health may contact you to clarify information or to request subsequent information; maintaining a copy of this form will provide you with the employee's written consent to communicate with these health professionals.
- The employee is responsible for any fees associated with the completion of this form.
- If you have any questions please call Homewood Health at 403-705-2024.

Thank you for your assistance!



ATTENDING PHYSICIAN'S STATEMENT

X 427 (R2021-04) B

To Be Completed By Employee

For Sickness & Accident (S&A) Benefits Only

(For Long Term Disability Income Benefits Application go to www.canadalife.com)

Employee Authorization & Signature Throughout the duration of this claim, I authorize any physicians(s) or other health care providers who have examined or treated me, to disclose all relevant information including any consultation reports to The City O Calgary's contracted short term or adjudication for adjudication for short term or ingerind isability provider (Canada Life Assumance Company) in the event of an appeal or to assist in the application or adjudication for short term or inger mid ability benefits. I understand that COMPENTIAL ITY of the information will be maintainstand. The information consoluted on this form its information and be directed to HR Support Services at 403 2468-5400 or Homewood Health at 405-705-2024. Have you been on an approved SAA claim or a function to the R Support Services at 403 2468-5400 or Homewood Health at 405-705-2024. Have you been on an approved SAA claim or a function to the R Support Services at 403 2468-5400 or Homewood Health at 405-705-2024. Have you been on an approved SAA claim or a function to the R Support Services at 403 2468-5400 or Homewood Health at 405-705-2024. Have you been on an approved SAA claim or a function to the R Support Services at 403 2468-5400 or Homewood Health at 405-705-2024. A transmitter of the information below to be completed by the attending physician) 1. Diagnosis: (including test results and relative clinical findings) 2. Objective Signs: (including test results and relative clinical findings) 3. Current Treatment: (include tesof hospitalization and any surgery performed	Employee's Name		Business Unit		Department Name		Date of Birth YYYY-MM-D	Employee ID #
Is illness/figury related to your work? If yes ask Dr. to complete WCB report. Yes In Troughout the duration of this claim. I authorize any physicants(s) or other health care providers who have examined or thereted me, to disclose a function of this claim. I authorize any physicants(s) or other health care providers who have examined or thereted me, to disclose a function of this claim. I authorize any physicants(s) or other health care providers who have examined or thereted me, to disclose a function or application or adjudication for short term of getter disability borolite. Indefinition or adjudication for short term of getter disability borolite. Indefinition or adjudication for short term of getter disability borolite. The information collected on this form is accordance with the Freedom of Information and Protection of Fivacy Act, Section 33(c). The information will be used to companies contracted by MEBAC and The City of Care Proteomocol Health at 432-762-202. Physician Information (information below to be completed by the attending physician) 0 1. Diagnosis: (include any complexitions and contributing factors, note if related to motor vehicle accident) 0 2. Objective Signs: (including test results and relative clinical findings) . 3. Current Treatment: (name & dosage of medication, type of therapy, etc. – note date medication/treatment started and response to date) 4. Pre-existing Condition(s): (note recurrences within the last year) 10. Date Next Visit 7. Other Treating Specialities/Practitioners: (indicate speciality, attach consultation reports) 10. Date Next Visit 8. Date Initial Visit for Condition 9. Date Impairmen	Home Phone XXX-XXX-XXXX	Position Title			Supervisor's Name		Supervisor's Phone	000-000-0000
Throughout the duration of the darin, lat thore any physicians(s) or other health care providers who have examined or treated me, to disclose al event information including any consultation reports to The City of Calgary's constructed short term disability provider (Homewood Health) and to report of term or ong term disability provider (Canada Life Assurance Company) in the event of an appeal or to assist in the application or adjudication for short term or ong term disability benefits. Lunderstand that COMPUTED TIVLUTY of the information will be used to confirm eligibility for benefits in understand that COMPUTED TIVLUTY of the information will be used to confirm eligibility for benefits in diversion and broaded between the started on this form is accorrance with the Freedom of Information and Protection of Privacy Act, Section 33(c). The information will be used to confirm eligibility for benefits understand that COMPUTED TIVLUTY of the information and broaded between all \$32,528,528,500 or Homewood Health at 403-705-2024. They used and an an approved S&A claim or a be directed between all \$32,500 or Homewood Health at 403-705-2024. They used and any approved S&A claim or a beine of the Support Saving at 403-268, 528,500 or Homewood Health at 403-705-2024. They used and any proved S&A claim or a beine of the Support Saving at 403-268, 528,500 or Homewood Health at 403-705-2024. They used any complications and contributing factors, note if related to motor vehicle accident) 2. Objective Signs: (including test results and relative clinical findings) 3. Current Treatment: (name & dosage of medication, type of therapy, etc. – note date medication/treatment started and response to date) 4. Pre-existing Condition(s): (note recurrences within the last year) 5. Hospitalization: (include dates of hospitalization and any surgery performed) 6. Pregnancy Related: (include EDC) 7. Other Treating Specialists/Practitioners: (indicate specially, attach consultation reports) 8. Date Initial Visit for Condition 9. Date	First Day Absent From Work YYYY-MM-DD		Is illness/injury related to your work? If yes ask Dr. to complete WCB report.					
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