CANADIAN ELEVATOR INDUSTRY WELFARE PLAN

Weekly Disability Income - Attending Physician's Statement

PART 1: PATIENT AUTHORIZATION ***(to be completed by patient, please print)***

Patient's Name:

Date of Birth: Day | Month | Year

I hereby authorize the release to Manion, Wilkins & Associates Ltd of any information contained on this form, and understand that Manion, Wilkins & Associates Ltd will use this information strictly to process my claim. I hereby authorize Manion, Wilkins & Associates to release my claim for the purposes of continuation of benefit coverage, long term disability (LTD) application and arrangements for return to work.
A photocopy of this release shall be as valid as the original.

Patient's signature: Date:

PART 2: ATTENDING PHYSICIAN'S STATEMENT ***(to be completed by physician, please print)***

1. Diagnosis of present condition
   a) Primary

   b) Additional conditions or complications which might affect duration of absence from work

2. To the best of your knowledge
   a) indicate when symptoms first appeared or accident happened *(day, month, year)*

   b) has patient had same or similar condition:
   [ ] yes [ ] no
   If yes, please state when and describe

3. Is condition due to injury or sickness arising out of patient's employment? [ ] Yes [ ] No [ ] Unknown

4. If patient is/was pregnant indicate date or expected date of confinement: *(day, month, year)*

5. Date of hospital in-patient admission *(day, month, year)* | Date of discharge *(day, month, year)*

6. Nature of treatment *(e.g. date and type of surgery)*

7. a) If patient was referred to you, give name of referring physician.

   b) If you have referred patient to a specialist, give name(s) of physician.

8. a) Date of first visit during present period of absence from work. *(day, month, year)*

   b) Date of latest attendance. *(day, month,year)*

   c) Were you actively supervising this patient's care during the full period
   [ ] No, comment in remarks
   [ ] Yes, state frequency of visits: [ ] Weekly [ ] Monthly [ ] Other (specify)

9. a) To the best of your knowledge, indicate period patient has been unable to work at own occupation as a result of present condition.
   From: *(day, month, year)* | To: *(day, month, year)*

   b) If still unable to work, give approximate date patient should be able to return *(day, month, year)* | or, the estimated number of weeks before possible return

10. Please advise how present condition affects patient's ability to work (i.e., restrictions, limitations, proposed surgery, etc.)

11. Remarks - Please provide comments and further details which you feel would be helpful.

Name of attending physician (please print) | Specialty | Telephone no. ( )

Address (number, street, city, province postal code)

Signature | Date *(day, month, year)*

The patient is responsible for securing this form and for any charges for its completion.

Please return completed form to your patient.