



Patient Authorization

(This section must be completed and signed by patient to authorize release of medical information).

Employee number

Contract number

50740

The Corporation of the City of Mississauga

Name - given and last name

Date of birth

**Attending Physician Statement
Weekly Indemnity: General**

I authorize the release to Sun Life Assurance Company of Canada of any information in respect of this claim.

Sun Life Assurance Company of Canada is a member of the Sun Life Financial group of companies.

Employee signature

Date

General Information

This form must be completed by a doctor of medicine

Is patient's condition due to injury or sickness caused by employment?

Last day at work

First day patient seen

Expected duration of disability

Yes **No** **Unknown**

Date of hospital in-patient admission

Date of discharge

Date and nature of surgery

Type of anaesthetic

Patient referred to you?

Name of referring physician

Have you referred patient?

Name of physician(s)/other

Yes **No**

Yes **No**

Date of first and all subsequent visits during present period of absence from work

Date first unable to work because of disability

Is patient competent to endorse cheques?

Yes **No**

Diagnosis

Primary

Secondary

History & Physical Findings

List all symptoms relevant to the claimed disability, noting severity, date of onset and progression

Treatment Plan

List medications, dosage and frequency

Remarks

Please note any psychological or social difficulties which may delay recovery

Prognosis

Please note any restrictions and/or limitations, and state prognosis

If Cardio-related:

Canadian Cardiovascular Class

OR

American Heart Association Class

If class 3 or 4 please enclose a copy of the report of the graded exercise test

Physical findings

Rhythm description

Angina (frequency, severity, patterns)

BP

Weight

Complications (i.e. cerebral vascular, peripheral vascular or diabetic conditions)

Investigations

Please enclose a copy of a current EKG and send copies of all relevant reports which objectively support the claimed disability described above (i.e. stress tests, echocardiograms, nuclear scans and angiograms).

Name of attending physician (please print)

Specialty

Telephone

Fax

Address

Physician's signature

Date

Please fax or mail to:

Toronto:
Fax: (416) 595-5243
PO Box 950 Str A
Toronto ON M5W 1G5