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

Attending Physician Statement Weekly Indemnity: Musculo-Skeletal/Motor Vehicle Accident

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

Name - given and last name

Date of birth DD MM YYYY

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

Employee signature

Date DD MM YYYY

General Information

This form must be completed by a doctor of medicine

Is patient's condition due to injury or sickness caused by employment? ☐ Yes ☐ No ☐ Unknown

Date of hospital In-patient admission DD MM YYYY

Date of discharge DD MM YYYY

Is patient competent to endorse cheques? ☐ Yes ☐ No

Last day at work DD MM YYYY

First day patient seen DD MM YYYY

Expected duration of disability

Patient referred to you? ☐ Yes ☐ No

Name of referring physician

Have you referred patient? ☐ Yes ☐ No

Name of physician(s)/other

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

Date first unable to work because of disability DD MM YYYY

Diagnosis

Primary

Secondary

Date symptoms appeared or accident happened DD MM YYYY

Has patient had same or similar condition ☐ Yes ☐ No

If yes, please state when and describe

History

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

Physical Findings

Weight

Height

If result of motor vehicle accident, give accident date DD MM YYYY

Expected return to work date DD MM YYYY

If no, please explain why not

Treatment Plan

List medications, dosage frequency and physiotherapy (Please note any psychological or social difficulties which may delay recovery)

Prognosis

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

Investigations

Please enclose copies of all relevant reports <u>which objectively support</u> the claimed disability described above (i.e. x-rays, myelograms, C.T. scans, bone scans, etc.)

Name of attending physician (please print)

Specialty

Telephone

Fax

Address

Physician's signature

Date DD MM YYYY

Please fax or mail to:

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

920-5695 (20/12/2000) 100308