



**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: Pregnancy**

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

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

**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	Date of discharge	Is patient competent to endorse cheques?
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Patient referred to you?	Name of referring physician	Expected duration of disability	
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	
Have you referred patient?	Name of physician(s)/other		
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____		
Date first unable to work because of disability	Para	Gravida	Expected due date
_____	_____	_____	_____ MM YYYY
Date of first and all subsequent visits during present period of absence from work			
_____			

**Diagnosis**

Primary	Secondary
_____	_____

**History & Physical Findings**

List all symptoms and abnormal physical findings relevant to the complications in this pregnancy. Please note severity, date of onset and progression. **Please enclose a copy of all relevant reports to support this claim (i.e. ultrasound, amniocentesis, hemogram, blood type, blood chemistry, urinalysis, prenatal records).**

\_\_\_\_\_

Pre-pregnant weight	Current weight	Height
_____	_____	_____

**Treatment Plan**

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

\_\_\_\_\_

Date of hospital admissions

\_\_\_\_\_

**Prognosis**

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

\_\_\_\_\_

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 Str A  
 Toronto ON M5W 1G5