VICTORIA UNIVERSITY
IN THE UNIVERSITY OF TORONTO

SHORT-TERM DISABILITY CLAIM FORM

ATTENDING PHYSICIAN STATEMENT

Personnel No. _____ Employee Name _____ Date _____

I authorize my doctor to exchange information with a medical practitioner appointed by Victoria University and/or Victoria University Human Resources Office.

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?

Yes

No

Unknown

Last day at work _____

First day patient seen _____

Subsequent visits if any _____

Expected duration of disability _____

Date of hospital in-patient admission (if applicable) _____

Date of discharge (if applicable) _____

Medical Condition

Does the employee suffer a medical condition which prevents him/her from carrying out the essential duties of: his/her job. Yes No

Impact of Condition

Able to perform essential duties? Yes No

Able to perform partial duties Yes Describe restrictions

_____

_____

Prognosis

A prognosis about the length of time the employee may suffer the medical condition and a forecast about the employee's ability to return to work.

Treatment Plan

Confirm that the employee is receiving treatment necessary for the employee to recover and return to regular duties

Certification

I am a medical doctor qualified to treat the medical condition of the employee and to develop a treatment program for this medical condition Yes No

The patient has been in my care for the above medical condition

Name and address of attending physican (please print)

_____

_____

Telephone _____ Fax _____

Physician's signature _____ Date _____

Please fax to (416) 921-4556 or mail to Victoria University, ATT: Human Resources, 73 Queens Park Cres. Toronto ON M5S 1K7