

**Attending Physician's Statement  
Long-Term Disability**

**Part 1: Assignment, Certification & Authorization**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

Policy number: \_\_\_\_\_ Date of birth (DD/MM/YYYY): \_\_\_\_\_

Name of employer: \_\_\_\_\_

**Authorization:**

I certify that the information in this form is true and complete and authorize the release of this information to the insurance company and their representatives. I understand that the claims analyst may investigate this claim. I authorize my employer, physician, practitioner, healthcare professional, hospital, healthcare institution, medical organization, clinic and other medically-related facility, insurance company, Workers' Compensation authority, Canada or Quebec Pension Plan and group plan administrator to release to and exchange with the claims analyst any medical or benefit payment information to process or manage my claim.

I agree that a photocopy of this authorization shall be as valid as the original.

I understand that I am responsible for any charges related to the completion of forms or medical reports.

Claimant's signature: \_\_\_\_\_ Date (DD/MM/YYYY): \_\_\_\_\_

**Part 2: Attending Physician's Statement**

**PLEASE ANSWER EACH QUESTION AND PROVIDE COPIES OF RELEVANT TEST RESULTS.**

**1. History of Illness or injury**

a) When did symptoms first appear or accident happen? (DD/MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

b) Date patient ceased work because of disability. (DD/MM/YYYY) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

c) Has patient ever had same or similar condition?  Yes  No  Unknown

If yes, state when and describe: (history, severity, frequency, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

d) Is this condition due to an occupational illness/injury?  Yes  No If yes, date of event (DD/MM/YYYY): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

e) Is the disability related to pregnancy?  Yes  No Expected date of delivery (DD/MM/YYYY): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Preventative leave?  Yes  No

**2. Diagnosis**

a) Primary \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

b) Secondary and/or complications: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

c) Subjective symptoms and general observations:

\_\_\_\_\_  
\_\_\_\_\_

d) Procedures and examinations (please include copies of results):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Attending Physician's Statement Long-Term Disability

### 3. Treatment

a) First visit: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last visit : \_\_\_\_/\_\_\_\_/\_\_\_\_ Next visit: \_\_\_\_/\_\_\_\_/\_\_\_\_  
DD MM YYYY DD MM YYYY DD MM YYYY

b) Frequency of visits:  Weekly  Monthly  Other (specify): \_\_\_\_\_

c) Medications (indicate dosage and date prescribed):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

d) Hospital admission - Name of hospital: \_\_\_\_\_ Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

e) Surgery - Type: \_\_\_\_\_ Date (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

f) Consulting Physician(s) - Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

g) Other specialist(s) - Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

h) Please provide details of other treatments administered: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

i) Are tests/investigations pending?  Yes  No If yes, please indicate date and description: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

j) Please describe response to treatment to date:  Complete  Partial  None  Too soon to tell

### 4. Cardiac condition (if related to disability) (Functional capacity according to the American Heart Association)

Class 1 (no limitation)  Class 2 (slight limitation)  
 Class 3 (marked limitation)  Class 4 (complete limitation) Blood pressure at last visit: \_\_\_\_/\_\_\_\_

### 5. Restrictions and limitations

Based on your clinical findings and observations, please describe the patient's current cognitive and physical restrictions and limitations:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### 6. Return to work

a) Estimated date of return to regular work (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

b) Date on which the patient is able to return to modified duties or other type of work (DD/MM/YYYY): \_\_\_\_/\_\_\_\_/\_\_\_\_

c) General comments:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 Attending physician's name (in block letters)

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Telephone number

\_\_\_\_\_  
 Physician's signature

\_\_\_\_\_  
 Specialty

\_\_\_\_\_  
 Date (DD/MM/YYYY)