DISABILITY MEDICAL REPORT – SALARY INSURANCE

PLEASE FILL OUT IN CAPITAL LETTERS

Section A: Identification of employee

Surname		Given name
Social insurance number	Sex ☐ Male ☐ Female	Date of birth ____/____/____ (Y M D)
Address	Province	Postal code
Date of beginning of disability ____/____/____ (Y M D)	Job title	

Section B: Identification of employer (to be completed by the employer)

Name of employer		
Address	Province	Postal code
Name of employer representative	Telephone no. ( )	Fax no. ( )
Signature		

Section C: Attestation and authorization of employee (to be completed by employee)

Have you filed, or do you intend to file a claim concerning your present disability under a law administered by one of the following organizations? (If so, please check the appropriate box.)

☐ IVAC: Indemnisation des victimes d'actes criminels

☐ SAAQ: Société de l'assurance automobile du Québec

☐ CSST: Commission de la santé et de la sécurité du travail

☐ RRQ: Régie des rentes du Québec

I certify that the information contained in this report is accurate, and I authorize the physicians and authorized representatives of hospitals and any other organizations concerned to provide the employer and Services-conseils aux gestionnaires des réseaux de l'éducation with any pertinent information concerning my health condition or medical history with regard to the disability described in this report. Upon request, I will submit to the employer the supporting documents attesting to the treatment received from any other health professional for the said disability.

Signature	____/____/____ (Y M D)	Phone no. at the residence ( )

General information intended for the attending physician and employee claiming salary insurance benefits

Salary insurance plan

The costs related to the salary insurance plan in the education network are assumed in their entirety by the employer for the first 104 weeks of disability. This is a self-insurance plan to which the employee does not contribute.

While the employer is responsible for the payment of salary insurance benefits, he or she must ensure that the benefits are paid in accordance with the rules governing the collective agreements in force in the education network.

The employer may, if he or she deems it appropriate, require additional information in order to enable him or her to assess the eligibility of the claim, as well as any extension of the absence. He or she may refer an employee to a physician he or she may designate. Any cost related to a medical report, such as professional fees or additional information, are assumed by the employee, unless otherwise stipulated in the collective agreements or working conditions. The employer handles the medical certificates and information in a confidential way.

Definition of "disability"

To be eligible for salary insurance benefits during a disability period, the employee must demonstrate that his or her medical condition meets the following three criteria:

1. the state of incapacity **must result from an illness, accident, pregnancy complication** or **surgical procedure related to family planning;**

AND

2. the illness (or accident) **necessitates medical care**;

AND

3. the disability must render the employee **totally unable to perform the usual duties of his or her position,** or **any other similar position** calling for comparable remuneration.

Gradual return to work

Any employee may, after agreement with the employer, benefit from a period of gradual return to work during which he or she must be able to perform all of his or her duties according to the agreed proportion of time.

Note: This document is intended for information purposes only and does not, in any circumstances, replace or add to the definitions contained in the collective agreements in force in the education networks.

Section D: Identification of employee

Name of employee	Social insurance number

Section E: Medical report (to be completed legibly by physician)

1. DIAGNOSIS

Principal: ______________________________

____

Secondary (if any): ______________________________

____

In the case of a mental disorder, fill in the axis according to DSM IV.

Axis I ______________________________

Axis II ______________________________

Axis III ______________________________

Axis IV ______________________________

Axis V ______________________________

Pregnancy: D.P.A.: _____/_____/____ (Y M D) Is it a serious complication? ☐ Yes ☐ No G.A.R.E. ☐ Yes ☐ No

2.TREATMENT

Date of first consultation for this disability: ______/______/______ (Y M D)

Frequency of visits: ☐ weekly ☐ bi-monthly ☐ monthly ☐ other

Referral to another physician: ☐ Yes ☐ No **If yes,** name of physician (specialty):______________________

☐ Medication - name – posology:

____

____

☐ Physiotherapy/ergotherapy: Date of beginning: _____/_____/______ (Y M D) Frequency: ______________________

☐ Psychotherapy: Date of beginning: _____/_____/_______ (Y M D) Frequency: ______________________

Did or will this person undergo:

☐ Examinations or tests (CSF, HB, ECG, EMG, CAT, RMI….) Specify:______________________ Results: ______________________

☐ Surgical ☐ same day Specify: ______________________ Date: _____/_____/______ (Y M D)

☐ Hospitalization from _____/_____/_____ (Y M D) to _____/_____/_____ (Y M D) Name of hospital or clinic: ______________________

☐ Other (specify):______________________

3. RETURN TO THE WORK PLAN AND PROGNOSIS

Date of start of disability: _____/_____/_____ (Y M D) Expected date of return to work: _____/_____/_____ (Y M D) If undefined, indicate approx. date of end of absence: _____/_____/_____ (Y M D)

Could the employee return to work on a gradual basis? ☐ Yes ☐ No **If yes,** date of start: _____/_____/______ (Y M D)

If yes, number of days/wk. and weeks: ___________ for ___________ (days/wk. weeks) ___________ for ___________ (days/wk. weeks) ___________for ___________ (days/wk. weeks)

Date of next appointment: ______/______/______ (Y M D)

4. DISABILITY (definition on reverse side)

Indicate how the illness described above renders the employee unable to hold the position entered in Section A. Indicate the **functional disabilities: (definition on reverse side)**

____

____

5. TOTAL PERMANENT DISABILITY (if any)

In your opinion, does the employee exhibit any total permanent disability? ☐ Yes ☐ No

If yes, could the employee carry on other employment? ☐ Yes ☐ No Have you completed documents for the RRQ? ☐ Yes ☐ No

Identification of physician

Only legally authorized physicians may sign the form (stamps not accepted). Please note that the employer is not bound by the recommendations of the signatory physician. **Any incomplete report, or any report whose content does not support the recommendations, could be refused without further notice.**

Name and surname of physician (please print)	Permit no.	Telephone no. ( )	Fax no. ( )
Specialty (if necessary)	Signature of physician		Date _____/_____/_____ (Y M D)

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