Attending Physician's Statement

Employee's name _____ McGill ID # _____

I authorize the release of any information with respect to this claim to my employer and/or his representative.

Employee's signature _____ Date _____

To the Attending Physician,

As a permanent employee of McGill University, your patient is eligible for salary continuance in the case of short term disability. McGill University manages its own short term disability plan. Please provide the following medical information to allow us to review your patient's eligibility for salary continuance.

DETAILS OF VISIT *(To be completed by the attending physician)*

Diagnosis: _____

Treatment Plan: _____

Examinations / tests (performed or prescribed): _____

The patient is referred to a specialist: ☐ Yes ☐ No Specialty / Name: _____

If applicable, please indicate: Date of surgery _____ Date hospitalized: From _____ to _____

Functional limitations, restrictions, complications preventing the patient from working: ☐ None

_____

_____

RETURN TO WORK

☐ The patient is able to return to his / her regular duties. If not:

A progressive return to work may be favorable to your patient. Please note that McGill University is committed to providing accommodation whenever possible.

☐ The patient can perform light duties respecting the following functional limitations:

_____

☐ The patient can perform a progressive return to work. Please indicate recommended schedule:

_____

☐ The patient is unable to work (due to the functional limitations mentioned in the section "Details of visit")

Anticipated return to work date: _____

Date of visit: _____ Date of next visit: _____

Comments:

PHYSICIAN INFORMATION

Name_____ License #_____

Signature _____Date _____

Address, phone #, and fax #, or clinic stamp

The employee is responsible for the completion of this form without expense to the University.