Salary Indemnity Plan—Short-term

100–550 West 6th Avenue, Vancouver, BC V5Z 4P2 • 604-871-1921 • 1-800-663-9163 • Fax 604-871-2287 • email: benefits@bctf.ca

THE PATIENT IS RESPONSIBLE FOR ANY FEES RELATED TO THE COMPLETION OF THIS FORM

Short-term—Certificate of attending physician—Sickness or accident claim—Page 1 of 2

Member information and consent: TO BE COMPLETED BY THE PATIENT

Patient's name: ___________________________, ____________________ SD no._____ Date of birth: ______________ _____, _____
surname legal first name e.g. 36 month day year

I hereby authorize the release of any information requested in respect to this form, to the claims' administrator of the Salary Indemnity Plan, rehabilitation service provider and their agents, and to independent medical examination providers, pursuant to *Regulation 3.4.*

Date: ________________________ ______, 20____ Patient's signature: **X** ____
month day year

Note: *for authorization purposes, if completing online, add electronic signature or type name unless, if* ***not*** *attaching TPP annual statement, then only physical signature is acceptable.*

Attending physician statement TO BE COMPLETED BY THE DOCTOR

*To qualify for benefits under this plan, your patient must be prevented, by illness or injury, from performing their normal employment duties
Diagnosis: if **psychological**, indicate the DSM diagnosis and if **pregnancy** related, indicate the specific complication diagnosed.

To allow us to make our assessment of your patients claim, please answer all questions in full.

I hereby certify that ____is being treated by me for (state in detail nature of illness or injury).

Primary diagnosis: ____

Secondary diagnosis or complications: ____

Pregnancy/childbirth – expected or actual date of delivery: _______________________________ _____, 20____
month day year

Is the medical condition expected to resolve after childbirth? ☐ Yes ☐ No

Is or was this diagnosis of sufficient severity to warrant your patients absence from performing their normal employment duties:
☐ Yes ☐ No

When did present illness begin, or accident occur: _______________________________ _____, 20____
month day year

From what date was the patient unable to perform their normal employment duties: _____________________________ _____, 20____
month day year

Full-time—date patient returned to work full-time or, date it is estimated that they can return to work full-time:
☐ fully returned ☐ estimated return _______________________________ _____, 20____
month day year

Part-time—date patient returned to work part-time or, date it is estimated that they can return to work part-time:
☐ percentage returned part-time _________% ☐ date or estimated return _______________________________ _____, 20____
month day year

If returning part-time, please provide details (e.g., schedule of the graduated return-to-work plan):____
____
____
____
____

Date Received by BCTF Income Security Division

Patient's name: ____________________, ________________ SD no._____
surname legal first name e.g. 36

For benefits beyond three months your patient will be required to provide supporting medical evidence indicating that they are receiving ongoing care and treatment by an appropriate licensed physician for their disability, or a registered professional as directed by an appropriate licensed physician except where the Plan Administrator is aware that the disability is terminal.

☐ **Patient is currently receiving ongoing care and treatment by a licensed specialist physician or a registered professional.**

Name of specialist or registered professional: ____________________

Type of specialty practice: ____________________ Date seen: ____________ _____, 20____
month day year

☐ **Patient has been referred to a licensed specialist physician or a registered professional.**

Name: ____________________ Type of specialty practice: ____________________

Date: ☐ Referral sent ____________ _____, 20____ - OR - ☐ Appointment ____________ _____, 20____

☐ **Patient condition does not warrant a specialist referral and will remain under the ongoing care and treatment of a general practitioner.**

Current treatment plan, please describe in detail including pharmacotherapy, physiotherapy, massage therapy, chiropractic therapy, psychologist, clinical counsellor or other as applicable: ____________________

____

____

____

For the purposes of your patient filing a WorkSafeBC claim:

1. Is the injury or illness work related? ☐ Yes ☐ No
2. Date of the event, injury or illness: ____________ _____, 20____
   month day year
3. Details of work-related illness/injury: ____________________

   ____
4. Has disability been reported to WorkSafeBC: ☐ Yes ☐ No ☐ Unknown

Attending physician (please print)				Physician's stamp
Address		Province	Postal code	
Phone	Fax			
Signature (*physical signature required*)		Date signed (YYYY-MM-DD)		

Return completed forms by:
Email: *benefits@bctf.ca*
Fax: 604-871-2287
Mail: 100–550 West 6th Avenue
Vancouver, BC V5Z 4P2

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