BCTF | Salary Indemnity Plan—Short-term (TFEU)

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

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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.*

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