Centre de services scolaire des Portages-de-l'Outaouais

Québec

DISABILITY MEDICAL REPORT - SALARY INSURANCE

Please print clearly

Section A : Identification of employee (to be completed by the employee)

Family name	First name	
Employee 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

Centre de services scolaire des Portages-de-l'Outaouais

Address **225, rue Saint-Rédempteur** **Gatineau**		Province **Québec**	Postal code **J8X 2T3**
Representative of employer **ÉTIENNE-MAMADOU BERTRAND**	Telephone n° (819) 771-4548, poste 855741	Fax n° (819) 771-8170	Email info-sante.srh@csspo.gouv.qc.ca
Signature			

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

Have you filed, or do you intend lo file a claim concerning your present disability under a law administered by one or 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 ls 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	Telephone n° ( )

General Information Intended for the Attending Physician and the Employee Claiming Salary Insurance Benefit

Salary Insurance Plan

The employer assumes the costs related to the salary Insurance plan in the education network in their entirety 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.

Definition of "Disability"

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

1. the stale or 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 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 or gradual return lo work during which he or she must be able lo perform all or his or her duties according lo the agreed proportion or Ume.

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

Section D : Identification of the Employee

Name of employee	Employee number

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

1. DIAGNOSIS

Main illness causing present disability :

_____

_____

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 EDC : _____/_____/_____ (Y M D)

Is this a serious compilation? ☐ Yes ☐ No

2. TREATMENT

Date of first consultation for the disability : _____/_____/_____ (Y M D)

Frequency of visits : ☐ Weekly ☐ Bimonthly ☐ Monthly ☐ Other

Referral to another physician : ☐ Yes ☐ No **If yes,** physician's name, specialty :

☐ Medication - name – dosage :

_____

_____

☐ Physiotherapy : Start date : _____/_____/_____ (A M J) Frequency : _____

☐ Psychotherapy : Start date : _____/_____/_____ (A M J) Frequency : _____

Has this person underwent :

☐ Tests (CSF, HB, ECG, EMG, CAT, MRI, AP….) Specify : _____ Results : _____

☐ Surgery ☐ one day Specify : _____ Date : _____/_____/_____ (Y M D)

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

☐ Other (specify) : _____

3. GRADUAL RETURN TO WORK AND PROGNOSIS

Date of beginning of disability : _____/_____/_____ (Y M D)

Expecting date of return to work : _____/_____/_____ (Y M D)

If undetermined indicate du approximate date of end of absence : _____/_____/_____ (Y M D)

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

If so, no. Of days/wk And week : _____ days/wk. for _____ week; _____ days/wk. for _____ week; _____ days/wk. for _____ week

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

4. DISABILITY

Indicate how the illness described above render the employee unable to hold the position entered in section A. Indicate the functional disability (definition on previous page) : _____

_____

_____

INTENSITY OF SYMPTOMS: ☐ Intermittent ☐ Minors ☐ Moderate ☐ Severe

5. TOTAL PERMANENT DISABILITY (if any)

In your opinion, does the employee exhibit any total permanent disability, which prevents him or her from carrying on his or her employment? ☐ Yes ☐ No

If so, could the employee carry on other employment? ☐ Yes ☐ No

Signature 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 signatory physician. Any incomplete report, or any report whose content does not support the recommendations, could be refused without further notice.**

Name of physician (please print)	Permit nº	Telephone nº	Fax nº
		( )	( )

Specialty (if necessary)	Signature of physician (do not use stamp)	Date
		_____/_____/_____ (Y M D)