PRINT FORM

Centre de services scolaire du Littoral
Québec

DISABILITY MEDICAL REPORT– Salary Insurance

Write legibly

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

Surname	Given name	Telephone no.
Employee number	☐ Male ☐ Female	Date of birth _____/_____/_____ (Y / M / D)
Addresse	Province	Postal Code
Job title	Do you have more than one job? ☐ yes ☐ no Does your inability prevent you from working your other jobs ? ☐ yes ☐ no	

Section B – Employer's identification as insurer for the first 104 weeks
(to be completed by the employer)

Name and addresse of employer Centre de services scolaire du Littoral, 789, rue Beaulieu, Sept-Îles, Québec	Province Québec	Postal code G4R 1P8
Representative of employer Mona Bond	Telephone no. 418-962-5558	Fax no. 418-968-2942
Signature	Email srh@csdulittoral.qc.ca	

Section C – Attestation and authorization of employee (to be completed by the 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, medical clinic and authorized representatives of hospitals and any other organizations concerned to provide the employer and their representatives with any pertinent information concerning my health condition or medical history with regard to the disability described in this report.

I also authorize my employer and its representatives to disclose this information to all persons and organizations if this information is necessary for the analysis and management of my claim for disability benefits.

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)

In the event that my employer request a medical expert, I authorize the medical report be forwarded to my physician. ☐ yes ☐ no

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

Salary insurance plan

The costs related to the salary insurance planare 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.

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 for a **medical evaluation** that 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** manner.

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*

Name of employee	*Employee number*

Section D – Medical report (to be completed legibly by physician)

1. Diagnosis

Principal : _____

_____

Secondary : _____

_____

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

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

Assessment of illness: ☐ minor ☐ moderate ☐ serious

2. Treatment

Date of first consultation:

_____/_____/_____ (Y M D)

Frequency of visits :

☐ weekly ☐ bi-monthly ☐ monthly ☐ other

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

Referral to another physician : yes no

If yes, name of physician (specialty) : _____

Examinations or tests (CSF, HB, ECG, EMG, CAT, RMI….)

Specify : _____ Results : _____

Medication - name – posology: _____

_____

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

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

☐ Other (specify) : _____

Did or will this person undergo:

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

☐ Hospitalization from _____/_____/_____ (Y M D) to _____/_____/_____ (Y M D)

Name of hosptial or clinic : _____

3. Disability

Indicate how the illness described above renders the employee unable to hold the position entered in Section A.

4. Comments

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

Expected date of return : ____/____/____ (Y M D)

If undetermined, indicate the approximate date of end of absence: ____/____/____ (Y M D)

Comments:

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. Not that the employer is not bound by the recommendations of the signing physician. **Any incomplete report, or any report whose content does not support recommendations, could be refused without further notice.**

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