Physician's Statement of Disability

SHEPP
People. Pensions. Results.

1 Patient Authorization

FORM ID: 023 CASE ID: _____

Member Information

First Name _____ Middle _____ Last Name _____

Date of Birth (dd/mm/yyyy) _____ Member ID# _____

I authorize all physicians and medical practitioners involved in the assessment, investigation and treatment of my disability to provide SHEPP with the information required for my application for pension accrual while disabled.

_____ _____

Patient Signature Date (dd/mm/yyyy)

2 Physician's Statement

Notes to the Physician

This form is designed to help process your patient's SHEPP application for pension accrual while disabled. SHEPP will not cover any costs associated with the completion of this form.
This section is to be completed by the physician and all questions must be answered in full.

Diagnosis

Primary diagnosis _____ Secondary diagnosis _____

Subjective symptoms _____

Objective findings (results of x-rays or other tests) _____

If relevant to your patient's disability, indicate:

Height _____ Weight _____ BP _____ Pulse _____

Did you recommend that your patient stop working due to this disability?

◯ No ◯ Yes, provide date you recommended that work stop and reasons for your recommendation:

Dates your patient consulted you for this disability and the names and dates of consultations with other physicians or specialists.

Has your patient had this or a related medical condition before? ◯ No ◯ Yes,

If yes, provide the consultation dates with you or other physicians to the best of your knowledge:

Are additional medical tests being arranged? ◯ No ◯ Yes, provide dates:

Instructions:

✓ **Submit this form to SHEPP**

✓ **Keep a copy for your files**

SHEPP recognizes and respects the importance of your privacy. Personal information collected is used for the purpose of administering your benefits under the Plan.

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2 Physician's Statement (continued)

Indicate the current treatment program by checking the appropriate box and describe in the space provided:

- ☐ Names and dosages of medications _____
- ☐ Interactive treatments (e.g. physiotherapy, counselling) _____
- ☐ Date and type of surgery _____
- ☐ Hospital admission/discharge dates _____
- ☐ Future plans for surgery _____

Note: Please attach copies of all completed medical investigations and test results.

We realize that predicting recovery time is difficult, however we require a clear expectation of the length of absence from work. Please provide the date you anticipate your patient will be able to return to work or the length of time expected for recovery.

If you are unable to provide an estimated date of recovery, please indicate the date you will re-assess your patient.

If the patient's condition is related to pregnancy, please indicate the expected date of delivery (dd/mm/yyyy) _____

Please provide any other relevant information (including other medical conditions, complications, or non-medical factors which may prolong your patient's disability).

3 Authorization

Thank you for your assistance with this application.

Please print, type or stamp your name, specialty and address:

Phone _____

Fax _____

Email _____

_____
Physician Signature

_____
Date (dd/mm/yyyy)