ATTENDING PHYSICIAN'S STATEMENT

X 427 (R2023-11)

For Sickness & Accident (S&A) Benefits Only

(For Long Term Disability Income Benefits Application go to www.canadalife.com)

Instructions for Form Completion

Employee

- This form is for the sole purpose of applying for S&A benefits for absences greater than 5 consecutive working days.
- **Fully** complete the top section of the form (**please print**).
- Review, sign and date the Authorization to Release Information.
- If your absence is, or is expected to be, greater than **5 consecutive working days but 21 calendar days or less**, take this form with the top section filled in, or email it to your physician, surgeon, specialist (cardiologist, dermatologist, neurologist, obstetrician, etc.), nurse practitioner, chiropractor, physiotherapist, psychologist or dentist, duly licensed and registered in Alberta, for completion. (**Note**: forms completed after your illness/injury has resolved may not be approved for S&A benefits).
- If your absence is expected to be **beyond 21 calendar days**, take this form with the top section filled in, or email it to your physician, surgeon, specialist (cardiologist, dermatologist, neurologist, obstetrician, etc.), or nurse practitioner, duly licensed and registered in Alberta, for completion.
- Any reference to "physician" on this form also refers to the medical practitioners eligible to complete the form.
- **To avoid delay in benefit payment**, ask your physician, or their receptionist, to fax or email this form to Homewood Health (The City of Calgary's health service provider) at **1-866-460-4645** or DisabilityManagement@HomewoodHealth.com.
- It is your responsibility to maintain regular contact with your supervisor during your absence and to notify your supervisor **prior** to returning to work. **For Transit Operators:** You must call VP Dispatch prior to 1500 hours the day prior to returning to work full duties. Should you require an accommodation, you must contact VP Dispatch as soon as possible in order to make appropriate arrangements.
- In order to protect the confidentiality of medical information, DO NOT give this form to your supervisor or other City of Calgary representative(s). Homewood Health will inform your supervisor and Pay Services of the status of your claim.
- A representative from Homewood Health may contact you to clarify information or to request subsequent information.
- You are responsible for any costs associated with the completion of this form not covered by your benefit plan.
- If you have questions, please call HR Support Services at 403-268-5800 or Homewood Health at 403-705-2024.

Attending Physician

- If employee's absence is, or is expected to be **21 calendar days or less**, this form may be completed by a physician, surgeon, specialist (cardiologist, dermatologist, neurologist, obstetrician, etc.), nurse practitioner, chiropractor, physiotherapist, psychologist or dentist, duly licensed and registered in Alberta. If absence is expected **beyond 21 calendar days**, this form is required to be completed by a physician, surgeon, specialist or nurse practitioner, duly licensed and registered in Alberta.
- Any reference to "physician" on this form also refers to the medical practitioners eligible to complete the form.
- As this form is used to determine eligibility for disability benefits and to assist the accommodation of ill/injured employees back into the workplace, **please complete this form with as much detail as possible**. Any delay in form completion may result in interruption or delay of the employee's pay.
- Please fax or email the completed form immediately to Homewood Health (The City of Calgary's health service provider) at **1-866-460-4645** or DisabilityManagement@HomewoodHealth.com.
- A representative or physician from Homewood Health may contact you to clarify information or to request subsequent information; maintaining a copy of this form will provide you with the employee's written consent to communicate with these health professionals.
- The employee is responsible for any fees associated with the completion of this form.
- If you have any questions, please call Homewood Health at 403-705-2024.

Thank you for your assistance!

ATTENDING PHYSICIAN'S STATEMENT

X 427 (R2023-11)B

For Sickness & Accident (S&A) Benefits Only

(For Long Term Disability Income Benefits Application go to www.canadalife.com)

To Be Completed By Employee

Employee's Name	Business Unit	Department Name	Date of Birth YYYY-MM-DD	Employee ID #

Home Phone XXX-XXX-XXXX	Position Title	Supervisor's Name	Supervisor's Phone XXX-XXX-XXXX

First Day Absent From Work YYYY-MM-DD	**Is illness/injury related to your work? If yes ask physician to complete WCB report.** ☐ Yes ☐ No

Employee Authorization & Signature

Throughout the duration of this claim, I authorize any physician(s) or other health care providers who have examined or treated me, to disclose all relevant information including any consultation reports to The City of Calgary's contracted short term disability provider (Homewood Health) and long term disability provider (Canada Life Assurance Company) in the event of an appeal or to assist in the application or adjudication for short term or long term disability benefits. I understand that CONFIDENTIALITY of the information will be maintained. The information collected on this form is in accordance with the Freedom of Information and Protection of Privacy Act, Section 33(c). The information will be used to confirm eligibility for benefits. Information may also be provided to companies contracted by MEBAC and The City of Calgary to provide the identified benefit coverage. Questions about the use of this information can be directed to HR Support Services at **403-268-5800** or Homewood Health at **403-705-2024.**

Have you been on an approved S&A claim or a long term disability claim within the past 6 months? ☐ Yes ☐ No	**Employee Signature**	**Date** YYYY-MM-DD

Physician Information (information below to be completed by the attending physician)

1. **Diagnosis:** (include any complications and contributing factors, note if related to motor vehicle accident)

2. **Objective Signs:** (including test results and relative clinical findings)

3. **Current Treatment:** (name & dosage of medication, type of therapy, etc. – note date medication/treatment started and response to date)

4. **Pre-existing Condition(s):** (note recurrences within the last year)

5. **Hospitalization:** (include dates of hospitalization and any surgery performed)

6. **Pregnancy Related:** (include EDC)

7. **Other Treating Specialists/Practitioners:** (indicate specialty, attach consultation reports)

8. Date Initial Visit for Condition	9. Date Impairment Commenced	10. Date Next Visit

RETURN TO WORK INFORMATION (ACCOMMODATION)

1. Date Fit for Modified Work Hours/Duties: (outline below)	2. Date Fit for Full Hours/Duties:

3. **Modified Work Hours:** (indicate hours to be worked & outline progression to full hours where applicable)

4. **Modified Work Duties:** (indicate restrictions to duties - i.e. lifting, reaching, pushing/pulling, kneeling, walking, sitting, climbing, standing, typing, driving/heavy equipment use, outside work, uneven terrain, etc. Specify weights (kg/lb) and duration where applicable.) Please include any cognitive limitations as well, if applicable.

Additional Comments

Physician Name/Specialty (Please Print)	Signature	Date YYYY-MM-DD

ISC: Confidential

Please fax or email the completed form immediately to Homewood Health 1-866-460-4645 or DisabilityManagement@HomewoodHealth.com to ensure timely payment of S&A benefits.
If you have questions, please call Homewood Health at 403-705-2024.
The employee is responsible for any fee associated with completion of this form.

Physician's Stamp or Address/Phone #