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DISABILITY MEDICAL REPORT – SALARY INSURANCE
PLEASE FILL OUT IN CAPITAL LETTERS

Section A: Identification of employee

Surname		Given name	
Social insurance number	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth ____ / ____ / ____ Y M D	
Address		Province QC	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		
Address	Province QC	Postal code
Name of employer representative	Telephone no. ()	Fax no. ()
Signature		

Section C: Attestation and authorization of employee (to be completed by 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.)		
<input type="checkbox"/> IVAC: Indemnisation des victimes d'actes criminels	<input type="checkbox"/> SAAQ: Société de l'assurance automobile du Québec	
<input type="checkbox"/> CSST: Commission de la santé et de la sécurité du travail	<input type="checkbox"/> RRQ: Régie des rentes du Québec	
I certify that the information contained in this report is 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 regarding 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	Phone no. at the residence ()

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

Salary insurance plan

The costs related to the salary insurance plan in the education network are 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 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. The employer handles the medical certificates and information in a confidential way.

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 in the education networks.

Section D: Identification of the employee

Name of employee	Social insurance number
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Section E: Medical report (to be completed legibly by physician)

1. DIAGNOSIS	
Main illness causing this disability:	In the case of a mental disorder, fill in the axis according to DSM IV.
Secondary (if any):	Axis I _____
	Axis II _____
	Axis III _____
	Axis IV _____
	Axis V _____
Assessment of disease: <input type="checkbox"/> Severe <input type="checkbox"/> Moderate <input type="checkbox"/> Mild	Diagnostic Code: _____
Pregnancy: D.P.A.: <u> </u> / <u> </u> / <u> </u>	Is it a serious complication? <input type="checkbox"/> Yes <input type="checkbox"/> No G.A.R.E. <input type="checkbox"/> Yes <input type="checkbox"/> No

2. TREATMENT	
Date of first consultation for this disability: <u> </u> / <u> </u> / <u> </u>	Frequency of visits: <input type="checkbox"/> weekly <input type="checkbox"/> bi-monthly <input type="checkbox"/> monthly <input type="checkbox"/> other
Referral to another physician: <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of physician (specialty): _____
<input type="checkbox"/> Medication - name – posology: _____	
<input type="checkbox"/> Physiotherapy/ergotherapy: Date of beginning: <u> </u> / <u> </u> / <u> </u>	Frequency: _____
<input type="checkbox"/> Psychotherapy: Date of beginning: <u> </u> / <u> </u> / <u> </u>	Frequency: _____
Did or will this person undergo:	
<input type="checkbox"/> Examinations or tests (CSF, HB, ECG, EMG, CAT, RMI....)	Specify: _____ Results: _____
<input type="checkbox"/> Surgical <input type="checkbox"/> same day	Specify: _____ Date: <u> </u> / <u> </u> / <u> </u>
In a case of a surgery, can the employee work while waiting for the surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Hospitalization from <u> </u> / <u> </u> / <u> </u> to <u> </u> / <u> </u> / <u> </u>	Name of hospital or clinic: _____
<input type="checkbox"/> Other (specify): _____	

3. DISABILITY (definition on reverse side)
Indicate how the illness described above renders the employee unable to hold the position entered in Section A. Indicate the functional disabilities (definition on reverse side)
In your opinion, is the employee currently totally unable to perform the usual duties of her/his job? <input type="checkbox"/> Yes <input type="checkbox"/> No

4. RETURN TO THE WORK PLAN AND PROGNOSIS	
Date of start of disability: <u> </u> / <u> </u> / <u> </u>	Expected date of return to work: <u> </u> / <u> </u> / <u> </u>
	If undefined, indicate approx. date of end of absence: <u> </u> / <u> </u> / <u> </u>
Could the employee return to work on a gradual basis? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, date of start: <u> </u> / <u> </u> / <u> </u>
If yes, number of days/wk. and weeks: _____ for _____ weeks	_____ for _____ weeks
Date of next appointment: <u> </u> / <u> </u> / <u> </u>	

5. TOTAL PERMANENT DISABILITY (if any)	
In your opinion, does the employee exhibit any total permanent disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, could the employee carry on other employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you completed documents for the RRQ? <input type="checkbox"/> Yes <input type="checkbox"/> 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. Any incomplete report, or any report whose content does not support the recommendations, could be refused without further notice.			
Name and surname of physician (please print)	Permit no.	Telephone no. ()	Fax no. ()
Specialty (if necessary)	Signature of physician	Date <u> </u> / <u> </u> / <u> </u>	