ATTENDING PHYSICIAN'S STATEMENT

MANION

PART 1: PATIENT AUTHORIZATION *(to be completed by patient, please print)*

Patient's Full Name:

Date of Birth: Day | Month | Year

I hereby authorize the release to Manion Wilkins & Associates Ltd. any information contained on this form, and understand that Manion Wilkins & Associates Ltd. will use this information strictly to process my claim. I hereby authorize Manion Wilkins & Associates Ltd. to release my claim to my Employer for the purposes of continuation of benefit coverage, incentive calculations, long term disability (LTD) application, and arrangements for modified return to work duties. A photocopy of this release shall be as valid as the original.

Patient's signature: Date:

PART 2: ATTENDING PHYSICIAN'S STATEMENT *(to be completed by physician, please print)*

1. Diagnosis of present condition
   a) Primary

   b) Additional conditions or complications which might affect duration of absence from work

2. To the best of your knowledge
   a) indicate when symptoms first appeared or accident happened (day, month, year)

   b) Has the patient had same or similar condition?
   [ ] yes [ ] no
   If yes, please state when and describe

3. Is condition due to injury or sickness arising out of patient's employment? [ ] Yes [ ] No [ ] Unknown

4. If patient is/was pregnant, indicate date or expected date of confinement: *(day, month, year)*

5. Date of hospital in-patient admission: *(day, month, year)* | Date of discharge *(day, month, year)*

6. Nature of treatment: *(e.g. date and type of surgery)*

7. a) If patient was referred to you, give name of referring physician.

   b) If you have referred patient to a specialist, give name(s) of physician.

8. a) Date of first visit during present period of absence from work *(day, month, year)*

   b) Date of latest attendance (day, month, year)

   c) Were you actively supervising this patient's care during the full period?
   [ ] No, comment in remarks
   [ ] Yes, state frequency of visits: [ ] Weekly [ ] Monthly [ ] Other (specify)

9. a) To the best of your knowledge, indicate the period patient has been unable to work at own occupation as a result of present condition.
   From: (day, month, year) | To: (day, month, year)

   b) If still unable to work, give approximate date patient should be able to retur *(day, month, year)* | Or, the estimated number of weeks before possible return

10. Please advise how present condition affects patient's ability to work (i.e., restrictions, limitations, proposed surgery, etc.).

11. Remarks (please provide comments and further details which you feel would be helpful and **attach a copy of your clinical notes**)

Name of attending physician (please print)	Specialty	Telephone no. ( )
Address (number, street, city, province, postal code)		
Signature	Date (day, month, year)	

The patient is responsible for securing this form and for charges made for its completion

Please return completed form to your patient or directly to:

Manion Wilkins & Associates Ltd.
626-21 Four Seasons Place, Etobicoke, Ontario M9B 0A5
Telephone: 416-234-5044 or 1-800-263-5621
Fax: 416-234-0127