WATERFRONT EMPLOYERS OF B.C.

400 - 349 RAILWAY STREET, VANCOUVER, B.C. V6A 1A4
TELEPHONE (604) 689-7184 FAX (604) 681-7447

ILWU – EMPLOYER ASSOCIATION HEALTH AND BENEFIT PLAN

APPLICATION FOR CREDITED HOURS – FOR PENSION, VACATION, RETIRING ALLOWANCE PURPOSES

Full Name _____ Employee Number _____

Union Local _____ Telephone Number ( )_____

YOUR STATUS:

___ Casual employee

___ Welfare paying casual employee

___ Union Member (If you were ineligible for weekly indemnity, WCB Wage loss or ICBC benefits)

REASON FOR HOURS TO BE CREDITED:

___ **WCB:** Please provide copies of your **first and last cheque stubs** of your WCB wage loss payments. Credited time will only be considered for work-related disabilities arising directly from Waterfront Employment -no credit will be granted past your WCB wage loss period.

___ **SICKNESS OR ACCIDENT:** Casual employees must provide a physician's statement indicating the **EXACT** dates of the time loss and the **NAME** of the illness or injury causing the time loss.

*****Requests that do not include all of the required information will be returned to you*****

Please forward all documentation to Employee Services, Waterfront Employers of BC.

PLEASE NOTE: APPLICATIONS FOR TIME WILL ONLY BE CONSIDERED FOR THE CURRENT AND IMMEDIATELY PRECEDING YEAR. REQUESTS SUBMITTED FOR TIME PRIOR TO THE IMMEDIATELY PRECEDING YEAR MUST BE REVIEWED BY THE GENERAL MANAGER AND MUST INCLUDE THE REASON FOR THE LATE SUBMISSION.

ALLOW AT LEAST THREE WEEKS FOR PROCESSING.

Signature: _____ Date: _____

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PHYSICIAN STATEMENT – To be attached to an application for Credited Time by Employees

Patient's Name (PLEASE PRINT BELOW)

Patient's Age	**Height**	**Weight:**	**Blood Pressure:**

Primary diagnosis for present disability

Secondary:

Is there evidence of alcohol or drug abuse? ☐ **Yes** ☐ **No** Is this condition a result of current alcohol or drug abuse? ☐ **Yes** ☐ **No**

To your knowledge, has the patient ever developed the same or a similar condition?

If yes, please state when?

If due to an accident, when did it occur?

Dates of Hospitalization	Was Patient in emergency only? If so, what treatment was provided?
Identify surgery performed	Was surgery recommended by a Physician? ☐ Yes ☐ No
Date of first visit for present disability	Date disability commenced

Dates of subsequent visits

Were you actively supervising this patient's care since his / her disability began?

☐ Yes If yes, state frequency of visits: weekly ☐ bi-weekly ☐ monthly ☐

☐ No If no, has this patient been referred to a specialist?

Please comment: _____

Specify Nature of therapy treatments

☐ Medication ☐ Chiropractor ☐ Massage Therapy ☐ Physiotherapy ☐ Psychotherapy
☐ Other (Specify)

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Would therapy treatment assist this patient's recovery now or in the future? Yes ☐ No ☐

If yes, state recommended frequency of visits per week: Yes ☐ No ☐

Describe how this condition disables the worker:

Please specify the signs and symptoms of the condition:

Name and dosage of drugs:

Specify referrals made and attach specialist consultation reports:

Identify dates and results of laboratory tests, x-rays, etc.

(a) The patient is medically fit for work: Yes ☐ No ☐

(b) If not, state anticipated time of recovery _____

(c) If yes, specify the date patient was fit for work: _____

THE PATIENT IS RESPONSIBLE FOR THE SECURING OF THIS FORM AND <u>ANY CHARGE</u> MADE OF ITS COMPLETION

Doctor's Signature: _____ Date: _____

Speciality: _____

Telephone # _____

Official Stamp Required for Doctor's Name & Address

Doctor's Name:

Street:
City:
Postal Code: _____

PATIENT AUTHORIZATION

I, the undersigned, hereby authorize any physician or other health professional, any hospital, clinic, or other medical or paramedical organization, or any other person or legal entity who has or who may have, in the future, information on me or my state of health or who has access to such information, to disclose same to the administrator of my employer's benefit plan.

SIGNATURE OF PATIENT : _____ DATE: _____