# 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

Employees currently receiving weekly indemnity or long term disability are already receiving credited hours. Completing this form is not necessary.

**REASON FOR HOURS TO BE CREDITED:**

___ **WCB:** Provide copies of your **first and most recent cheque stubs** of your WCB wage loss payments (no physician's report is required). Credited time will be considered for work-related disabilities arising directly from waterfront employment, no hours will be granted past your WCB wage loss period.

___ **SICKNESS/ACCIDENT/BIRTH:** Employees must provide a physician's statement detailing the **EXACT** dates of time loss and the **NAME** of the illness/ injury causing the time loss (or provide a copy of the birth certificate in case of a birth). **If your application is for depression, anxiety or other psychological reasons, the physician's report must be completed by a psychologist, not a family doctor.**

*****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 will be reviewed by the manager and must include the reason for the late submission.**

**ALLOW AT LEAST THREE WEEKS FOR PROCESSING.**

Signature: _____ Date: _____

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## CREDITED TIME - PHYSICIAN STATEMENT
## ILWU – Employer Association Health & Benefit Plan

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The Patient is responsible for ensuring this form is completed by his/her Attending Physician and is responsible for any charges for preparing this form.

PATIENT NAME: _____ EMPLOYEE #: _____

**ATTENDING PHYSICIAN STATEMENT**:

**Primary Diagnosis** for current disability (please describe):

_____

_____

Please describe the signs and symptoms of this condition preventing patient from working:

_____

_____

Is there a **Secondary condition** contributing to the present condition? If so, please describe.

_____

_____

Has the patient ever developed the same or a similar condition? If so, when?

_____

Date of commencement of disability: _____

Date of first visit for present disability: _____

Dates of subsequent visits for present disability: _____

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Is there currently evidence of alcohol or drug abuse? YES ☐ NO ☐

Is the current disability the result of alcohol or drug abuse? YES ☐ NO ☐

Was the patient admitted to hospital for treatment? YES ☐ NO ☐

If YES, please provide dates of hospitalization _____

Is surgery required as treatment for this condition? YES ☐ NO ☐

If YES, please provide date of surgery _____

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## TREATMENT PLAN

Please specify any Specialist Referrals made:

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Required Treatments (please specify those that apply):

- ☐ Medication
- ☐ Physiotherapy
- ☐ Chiropractor
- ☐ Psychologist
- ☐ Massage Therapy
- ☐ Psychiatrist

Please provide frequency of treatments above:

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If medications are required, please provide drug name and dosage:

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Are further tests required to complete a diagnosis or treatment plan? If so, what tests are pending? When?

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**Is patient currently medically fit for work?** YES ☐ NO ☐

**If NO, state anticipated time of recovery** _____
(DD/MM/YYYY)

**If a specific recovery date in unknown at present, please provide reason:**_____

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Doctor's Signature: _____ Date: _____

Specialty: _____ Telephone # _____

**Official Stamp Required for Doctor's Name & Address**

Doctor's Name:
Street:
City:
Postal Code:

## PATIENT AUTHORIZATION

I, the undersigned, hereby irrevocably authorize any physician or other health professional, any hospital, 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 the ILWU – Employer Health & Benefit Plan.

Signature of Patient: _____ Date: _____