Waterfront Employers
British Columbia
400 – 349 Railway Street, Vancouver, BC V6A 1A4
t (604) 689 7184 | f (604) 681 7447

WEEKLY INDEMNITY SUPPLEMENTARY DISABILITY BENEFIT PHYSICIAN STATEMENT
ILWU – Employer Association Health & Benefit Plan

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

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: _____

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:

Required Treatments (please specify those that apply):

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

Please provide frequency of treatments above:

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

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

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:_____

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: _____