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

WEEKLY INDEMNITY SUPPLEMENTARY PHYSICIAN PROGRESS REPORT
ILWU – Employer Association Health & Benefit Plan

This report is to be completed by the Doctor who has been treating you during your current period of disability. You are responsible for ensuring this form is completed by your Attending Physician

PATIENT NAME: _____ EMPLOYEE #: _____

ATTENDING PHYSICIAN STATEMENT:

CLINICAL FINDINGS (please describe):

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

Is there a **Secondary condition** or any other contributing factors delaying the Patient's recovery? Please specify.

Dates Patient has visited your office for current disability: _____

TREATMENT PROGRAM

Surgery: _____ Date Performed: _____

Further Tests: _____ Date Performed: _____

Drug Prescribed (name & dosage): _____

Therapy:

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

- *Please provide a DSM number: _____

Frequency: _____

Is the Patient complying with the Treatment Program? YES ☐ NO ☐

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REFERRALS (please specify):

Doctor's Name	Speciality	Dates of Appointments
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CONCLUSION: In your medical opinion

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

If **YES**, what date was the patient fit to resume work: _____
(DD/MM/YYYY)

If **NO**, what is the anticipated date of recovery: _____
(DD/MM/YYYY)

If a specific date of recovery is **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: _____