Physician's Report to Disability Management Group (DMG)

Please send this form to the appropriate Disability Management Group by fax or by mail using the above address information.

☐ ***Short Term Disability Program***
Manulife Financial (Confidential)
Groupe de gestion de l'invalidité
2000, Mansfield street
P.O. Box 400, STN Place-D'Armes
Montreal QC H2Y 3H1
Telephone : (514) 287-4393 * (1-866) 364-4393
Fax : (514) 287-4394 * (1-866) 364-4394

☐ ***Long Term Disability Program or Accident Disability Benefits***
Bell Canada (Confidential)
1, Alexandre G. Bell
Tour A, Floor 3
Verdun (Québec) H3E 3B3
Telephone : (514) 870-2975 * (1-800) 228-7731
Fax : (514) 391-2272 * (1-888) 391-2272

Form ☐ *initial or* ☐ *supplementary* Employee No : ______ Tier B (CP4) : ______ Organization Code : ______ Cost Centre : ______

To the employee:

In the event that you are absent from work for more than seven calendar days for illness/off-duty injury, or for one full day for an on-duty injury/ occupational disease*, complete Section A below and give this form to your attending physician. The BC 1935 form must be returned, duly completed and signed, no later than 10 business days after your first day of absence.
**** In Ontario, this BC 1935 is to be used for on-duty injuries or occupational disease whereas in Quebec, the forms provided by the Commission de la Santé et de la Sécurité du travail du Québec (CSST) are to be used.***

Section A — *(to be completed by the employee)*

Surname, Name ______

Home Address ______

Tel. No. ( ) ______

Immediate Supervisor Name ______

Title ______

Address ______

E-mail ______

Tel. No. ( ) ______ Fax No. ( ) ______

Administrative Assistant Name ______

Address ______

E-Mail ______

Tel. No. ( ) Fax No. ( )

Employee status: ☐ *Full-time or* ☐ *Part-time*

Date of birth: Year Month Day

Net credited service date: Year Month Day

Current job start date: Year Month Day

Last day worked: Year Month Day

First day of absence: Year Month Day

Job title: ______

In the case of an accident, describe the incident

______

______

Employee Authorization (choose either Option A or Option B – Note that if no choice is made the form will be returned to the employee as incomplete):

Option A — *(to be completed by the employee)*

☐ I hereby authorize any physician or other health professional, hospital, insurance company or any other medical, rehabilitation or other professional establishment including the Canada Pension Plan/Régie des rentes du Québec/Ontario No Fault Benefits/Société de l'assurance-automobile du Québec, having medical information relative to my current absence to disclose to the Bell Disability Management Group and/or its designated agents (the DMG) all medical information requested regarding my current absence from work and to discuss my work capacity with the DMG.

Option B — *(to be completed by the employee)*

☐ I hereby authorize the undersigned physician and any medical specialist to whom I have been referred by the undersigned physician, to disclose to the Bell Disability Management Group and/or its designated agents (the DMG) all medical information requested regarding my current absence from work and to discuss my work capacity with the DMG.

Please note regardless of which option is chosen:
1. An additional medical information release may be required by DMG to confirm initial and/or ongoing eligibility to the disability program.
2. The DMG will use information obtained to assist in managing the current absence. This authorization is valid for a maximum period of six months.
3. The Company warrants to collect, use, disclose and safeguard all information in accordance with the Personal Information Protection and Electronic Documents Act (PIPEDA).
4. The employee shall inform the DMG of activities such as attending school or performing work outside of Bell during the current absence.
5. The patient understands that any costs inherent to obtaining the present physician's report are at the patient's expense.

Employee signature: ______

Date : 20_____/_____/_____
Y M D

Section B — *(to be completed by the duly certified physician or dentist)*

To the physician: The information you provide will be used in a confidential manner to manage the employee's medical file. Bell believes that it is in the employee's best interest to resume work, even if on a part-time basis, as soon as medically feasible. The company will try to arrange suitable interim assignments respecting the employee's limitations.

NAME ______________________ **EMPLOYEE NO.** ______________________

1 Patient's name ______________________ Height (if relevant) __________ Weight (if relevant) __________

2 Diagnosis of current disability (for mental health problems, use DSM-IV nomenclature)

A) Primary ______________________ B) Secondary (if relevant) ______________________

C) Date of first visit: Year / Month / Day   Last visit: Year / Month / Day   Next appointment: Year / Month / Day

D) Has the patient suffered previously from this or a similar condition? (If so, when? Provide details.)

____

E) To your knowledge, when did the symptoms first occur? ______________________

F) If the patient suffers from high blood pressure relative to current absence, indicate the last three readings:

_____ / _____ Year / Month / Day ˌ _____ / _____ Year / Month / Day ˌ _____ / _____ Year / Month / Day

G) If the ailment is the result of a pregnancy complication, indicate the expected data of delivery: Year / Month / Day

3 Is the diagnosed disability the result of: illness? ☐ ☐ work-related illness (WSIB/CSST)?

accident? ☐ *work-related (WSIB/CSST)* ☐ *non-work related* ☐ *automobile*

4 Treatment

A) Nature and frequency of current treatment ______________________

B) Type and dosage of medication relative to the current absence ______________________

C) Results of pertinent laboratory tests and/or X-rays ______________________

D) Has the patient been referred to a specialist for the current absence? If so, indicate the referral date, specialist's name and specialization:

__________ __________ __________

E) If the patient has been hospitalized, indicate the reason and period: ______________________

F) If the patient has undergone or is to undergo surgery, indicate the nature and date: ______________________

5 Extent of disability

A) In your opinion, is the patient totally incapable of performing all of his/her usual job-related tasks? ☐ Yes ☐ No

If so, why? ______________________

____

If not, specify which tasks cannot be performed. ______________________

____

B) In your opinion, is the patient able to perform another job? ☐ Yes ☐ No

If so, specify the nature of his/her functional limitations or work restrictions. ______________________

____

How long will these functional limitations or work restrictions apply? ______________________

C) Do you have a progressive return-to-work plan to suggest? ☐ Yes ☐ No

If so, describe the plan. ______________________

____

D) When do you expect the patient to be able to return to his/her regular job? Year / Month / Day

E) If the illness is cardiac-related, indicate the current functional class:

☐ Class 1 (no restriction) ☐ Class 2 (slight restriction) ☐ Class 3 (severe restriction) ☐ Class 4 (complete restriction)

F) If you expect the absence from work to be longer than that normally associated with the diagnosis, specify the factors justifying the prolongation:

____

G) Would the patient benefit from assistance on returning to work? ☐ Yes ☐ No

If so, explain: ______________________

Physician's name: ______________ Signature: ______________ Date:: 20_____/_____/_____

Specialization: __________ Licence No.: __________ Fax No.: (   ) __________ Tel. No.: (   ) __________

NOTE: The patient is responsible for any cost involved in obtaining this report.