"TIER ONE" – MAY BE REQUETED 1 of 2 pages

SHORT TERM DISABILITY FORM — ABSU

Employee and Attending Physician Statement (Pg. 1/2)

Please note that any charges for the completion of this form are the Employer's responsibility.
For assistance, please call 1-800-303-0248
Fax completed form to Oncidium Health Group at 1-877-424-4424

I AUTHORIZE my physician to complete this Physician Statement and send it to the Oncidium Health Group. I also authorize Oncidium to provide a summary of my status to the Employer.

Employee's Signature ______________________ Date (d/m/y)________________

Part A. Employee Information – To be completed by the Employee:		
Last name: First Name	Male: ☐ Female: ☐	Date of Birth:
Company Name:	Team Manager Name:	
PLEASE ensure to INCLUDE: AREA CODE, TELEPHONE NUMBER AND APARTMENT NUMBER (if applicable).		
Home Telephone: ( )	Work Telephone: ( )	
Address:		
(Street and Apt. #) (City)	(Province)	(Postal Code)

1. Is your condition the result of an accident at work? Yes ☐ No ☐
2. If your condition was the result of an accident at work, please provide the date ______________
3. Were you admitted to hospital for this illness or injury? Yes ☐ No ☐
4. Date last treated by a doctor for this condition: ____________________ (d/m/y)

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Employee's name: ____________________

Part B. Attending Physicians Statement – To be completed by the Treating Physician/Specialist

Please ensure the form is completed in full (include the employee's name at the top of the page).

1. The general nature of the above individual's illnes s or injury is (do not identify diagnosis)

   ____

2. Please provide the date of the Individual's latest visit in connection with the present illness or injury: ____________________

3. Please indicate whether this individual's condition arises out of the course of employment:

   Yes ☐ No ☐ Unknown

4. I estimate that this employee will be able to return to work on ____________________

5. Will this employee require accommodation upon his/her return to work?

   Yes ☐ No ☐

Name of Attending Physician (PLEASE PRINT):

____

____________________ Signature

____________________ Date (d/m/y)

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