Supplementary Income Replacement Application

This form is required for absences, due to a personal non-occupational disability, that are in excess of five (5) working days. It must be submitted to the Disability Management Section of Human Resources by the seventh (7th) day of absence. Delaying your submission may result in a disruption to your pay.

Employee Name:		Employee ID/PR #:	Dept. #:
Position:	Address:		Home Phone:
City/Town:	Prov:	Postal Code:	Alt. Phone:
Supervisor Name:			Supervisor Phone:
First Day/Shift Absent:			

Consent to Release Information:

If the medical information I have provided is deemed inadequate by the City of Edmonton, I understand that a Disability Management Consultant may contact me to obtain additional information.

By placing my initials in this space _____ I hereby authorize the Disability Management Consultant to contact my physician, Dr. _____ to provide additional medical information including my functional capabilities, as it may be required for adjudicating and managing my claim and assessing return to work opportunities. I understand that prior to contacting my physician, the Consultant will make reasonable attempts to contact me by telephone to advise me of their intention to contact my physician. My consent to permit access to additional medical information provided by my physician, as it relates to my current absence, will only be valid for 180 days.

I understand that it is my responsibility to gather and forward required medical information in a timely manner or risk a delay in the adjudication of my claim and possible non payment of the claim. Furthermore, I understand that if disability benefits have already been received and I fail to provide sufficient medical information to substantiate the claim, all or some of the funds may be recovered from me. I also understand that it is a serious offence punishable by discipline and/or dismissal to falsify any information on this form; I hereby certify that the statements made by me are true and correct.

All City of Edmonton employees wishing to leave the greater Edmonton area while absent from work due to illness/injury must obtain prior approval from their Disability Management Consultant. Without prior approval, the employee may not be entitled to receive benefits during the whole period he/she remains outside the greater Edmonton area.

Employees must pay the physician directly and then will be reimbursed up to $40.00 for costs associated with completion of this form. Incomplete or illegible medical forms may not be covered. Employees must submit their receipts with this form to Disability Management Services, 9th Floor, 9803-102A Ave, Edmonton, AB, T5J 3A3 or by Fax: 780-496-9227, or by email to: hr-disabilitymanagement@edmonton.ca

Employee Signature: _____ Date: _____

Page 1 and 2 must be submitted together. All questions must be answered in full and information provided must be legible. Failure to meet these requirements may result in non payment of benefits. Please have Page 2 of this application form completed by a licensed physician.

Submit completed form to:
Disability Management Services, 9th Floor, Century Place, 9803 102A Ave NW
Edmonton, AB T5J 3A3
Fax: 780-496-9227
Email: hr-disabilitymanagement@edmonton.ca

Supplementary Income Replacement Form
(due to personal non-occupational disability)

Must be completed by the Physician.
All questions must be answered in full and legible. Failure to meet these requirements may result in non payment of benefits. Please call 780-496-8835 if there are questions regarding form completion.

Patient Name:	Date of first visit:

Nature of illness/injury:

If applicable please provide: DSM-V:

Description of treatment plan including any prescribed medications:

Please indicate which of the following situations is immediately suitable:

Not fit for any work ☐	Interim work placement ☐	Medium duties ☐	Light duties ☐	Regular duties ☐
Significant limitations to functioning ability. Requires bed rest and should be confined to home or hospitalized. Intensive therapy or treatment. Post-op recovery, etc.	Functional limitations allow for sedentary activity. Alternating between sitting and standing, no requirements to lift, carry, or climb. May require reduced hours of work.	Functional limitations not significantly impaired. Needs to stand, walk, and sit as required. Limit lifting, carrying, pushing and pulling to <15 kg. Limit climbing.	Moderate functional restrictions, able to stand, sit as required. Some walking, limited lifting, pushing and pulling to <10 kg carry. No climbing.	Current functioning level supports a return to full duties. No limitations.

Prognosis : (Duration of Disability) When do you anticipate that your patient will be able to return to work?	Modified duties: Regular Duties:

Specify functional limitations preventing your patient from performing his/her job:

	Yes	No
Environmental Sensitivities?	☐	☐
Driving Restrictions?	☐	☐
Cognitive Impairments?	☐	☐

If yes to any of the above, please explain:

Follow up:

Is your patient required to see a specialist or undergo diagnostics? Yes ☐ No ☐	Date of next appointment with attending physician:

Physician Signature: _____ Date: _____

Physician Name:	Phone:	Fax:

Is this work related? Yes ☐ No ☐ If yes, the City will report to WCB in accordance with the Worker's Compensation Act Section 33.

Bill patient directly for the completion of this form. Max. employee reimbursement is $40.00

All personal information is collected under the authority of section 33(c) of the *Freedom of Information and Protection of Privacy Act*. It will be used in the administration of Human Resources policies and programs, including eligibility for disability benefits and development of return to work plans. It is protected by the privacy provisions of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, contact Disability Management Services, 9th floor Century Place, 780-496-8835.

THE CITY OF Edmonton HUMAN RESOURCES

Form #: HR075
Version: 2013.07.17