CONFIDENTIAL

MEDICAL ABSENCE REPORT

Employees are responsible for fees charged for completing this form, unless otherwise provided for in the applicable collective agreement. Once completed, make sure the form is submitted to Alight Disability Management **no later than 10 calendar days** after the **first day of absence**. Failure to return the completed form in the allotted time will result in benefits being denied at this time. In some cases, medical documentation may be submitted in another type of medical form as long as it contains the information requested in this form.

Upload your medical documentation In AbsenceConnect, the Disability Management System at Alight.

or

Submit it by email to Alight's Disability Management team at LVS-medabsence@Alight.com.

PART A - EMPLOYEE INFORMATION AND CONSENT - To be completed by the employee

SURNAME	FIRST NAME	EMPLOYEE I.D.	DATE OF BIRTH (yy/mm/dd)
HOME ADDRESS		POSTAL CODE	PHONE #
DEPARTMENT		JOB TITLE	FIRST DAY OF ABSENCE (yy/mm/dd)
SUPERVISOR		SUPERVISOR'S PHONE #	PLACE OF WORK

CONSENT:

As per the Privacy Act, the purpose for which this information is used, collected and may be disclosed is to enable CBC/Radio-Canada Disability Leave Specialists (including their agents and legal representatives such as Alight) to follow the progress of your illness, to determine, manage and adjudicate your eligibility for benefits, to facilitate rehabilitation and return to work including accommodation requests and attendance management, as well as for the employer's and policy holder's statistical or audit purposes.

Any medical information provided will be kept in strict confidence in your medical file. Except for the functional limitations and other information required to facilitate a successful return to work of an individual employee, medical information will not be shared with the employee's supervisor.

By completing and signing this form:

> I hereby authorize the exchange of my personal and confidential medical information related to my current absence from work between my physician(s), health professional(s), hospital(s), clinic(s), workers' compensation body(s), Canada Life Insurance Company (including its successors) and CBC/Radio-Canada's Disability Leave Specialists (including their agents and legal representatives such as Alight). The information provided is for the purpose of determining my fitness to work and/or to substantiate my absence due to illness and/or eligibility for benefits and/or the need for any accommodation in my workplace, including my early and safe return to work plan (if needed), and anything in relation to these topics.

Employee signature: _____ Date: _____

PART B - ILLNESS/INJURY INFORMATION - To be completed by Physician

DATE OF FIRST VISIT FOR THE CURRENT ABSENCE (yy/mm/dd)	**DATE OF NEXT APPOINTMENT** (yy/mm/dd) **OR FREQUENCY OF VISITS**
WHEN DID SYMPTOMS FIRST START (yy/mm/dd)	**EXPECTED DATE OF RETURN TO WORK** (yy/mm/dd) ***IF THE ABSENCE IS 10 WORKING DAYS OR LESS***
THIS DISABILITY IS THE RESULT OF: Personal Illness or accident ☐ Car Accident ☐ Occupational Illness* ☐ Accident at work* ☐ *If checked, have the forms been submitted to the appropriate provincial board? Yes ☐ No ☐ Are the medical services provided eligible for coverage under the public plan? Yes ☐ No ☐	**NATURE OF ILLNESS/INJURY** ***AS APPLICABLE IN RELEVANT JURISDICTION***
IS, OR WAS, THE EMPLOYEE HOSPITALIZED? Yes ☐ No ☐ If Yes: From : _____ To: _____ (yy/mm/dd) (yy/mm/dd)	**IS THE CURRENT ILLNESS A COMMUNICABLE DISEASE?** Yes ☐ No ☐ In the affirmative, has the communicable disease been reported to Public Health as required by law? Yes ☐ No ☐

OTHER ELEMENTS RELATED TO THE PATIENT'S INABILITY TO PERFORM HIS/HER JOB DUTIES:

ADDITIONAL COMMENTS:

PART C - ILLNESS/INJURY INFORMATION
To be completed by Physician - ONLY if the absence is expected to last more than 10 working days

IN MY OPINION, SUPPORTED BY OBJECTIVE MEDICAL EVIDENCE, THE PATIENT IS:

1. ☐ **TOTALLY DISABLED** from performing the regular duties of the occupation in which he/she participated immediately before becoming disabled. If not totally disabled, move to #2.

Explain how this (these) condition(s) impact(s) the patient's inability to perform his/her job duties (clinical effects of the condition):

Expected date of return with or without modified duties (yy/mm/dd): _____

2. ☐ **NOT TOTALLY DISABLED** from performing the regular duties of the occupation in which he/she participated immediately before becoming disabled. If applicable, specify restrictions below.

Physical Capabilities:

☐ **Sedentary Duties:** Sitting, no requirement to lift, carry, push/pull or climb.

☐ **Light Duties:** Standing and/or sitting Walking from one task area to another No climbing Limited carrying no greater than 5 kg Limited lifting, pushing or pulling no greater than 10 kg

☐ **Medium Duties:** Standing, walking, sitting as required, limited lifting, carrying, pushing or pulling no greater than 15 kg Limited climbing

Cognitive Capabilities – If applicable, please indicate if limitations in cognitive function:

Coherent ☐ Yes ☐ No

Judgment ☐ Good ☐ Adequate ☐ Poor

Concentration ☐ Good ☐ Adequate ☐ Poor

This individual can work ☐ Independently ☐ With supervision ☐ With assistance

Recommended work hours:

☐ full-time
☐ modified: (specify) _____

Explain how this (these) condition(s) impact the patient's ability to work full-time hours:

Other restrictions (based on job function):

Expected date of return with or without modified duties (yy/mm/dd): _____ **Estimated duration of restrictions:** _____

OTHER RELEVANT ILLNESS/INJURY INFORMATION:

☐ **Medical imaging & X-Ray** Specify: _____ Date: _____ ☐ **Other** Specify: _____ ☐ **Referred to a specialist** Specify: _____

I CONFIRM THAT THE EMPLOYEE IS UNDER MY ACTIVE AND CONTINUOUS CARE AND IS FOLLOWING THE TREATMENT I HAVE PRESCRIBED. Yes ☐ No ☐

PROGRESS AND RESPONSE TO TREATMENT: ☐ RECOVERY ☐ IMPROVEMENT ☐ NO IMPROVEMENT ☐ REGRESSION **PROGNOSIS FOR RETURN TO REGULAR DUTIES:** ☐ GOOD ☐ POOR ☐ UNCERTAIN

PART D – TO BE COMPLETED BY PHYSICIAN

PHYSICIAN'S NAME (PRINTED)	SPECIALITY	TELEPHONE	FAX
PHYSICIAN'S SIGNATURE		LICENSE NUMBER	DATE (yy/mm/dd)