BOILERMAKERS' NATIONAL BENEFIT FUNDS (CANADA)
Administration Office
45 McIntosh Drive, Markham, Ontario L3R 8C7

Boilermakers' National Pension Fund (Canada) Plan Registration Number 0366708 and Boilermakers' National Health and Welfare Fund (Canada)

SPECIAL DISABILITY BENEFIT ATTENDING PHYSICIAN'S STATEMENT

Please submit this completed form to the Boilermakers' National Health and Welfare Fund (Canada) Plan Administration Office, 45 McIntosh Drive, Markham, Ontario L3R 8C7

Instructions:

1. Please print.
2. Part 1 to be completed by Plan Member / patient.
3. Part 2 to be completed by Physician.

PART 1: PLAN MEMBER AUTHORIZIATION

Member's Name: _____ Date of Birth: _____/_____/_____
Day Month Year

Address: _____
Number Street City Province

_____ _____
Postal Code Phone Number

I attest that I am not currently working or, if I am working, that I have informed the Boilermakers' National Health and Welfare (Canada) Plan Administration Office. I hereby authorize the release to the Boilermakers' National Health and Welfare Plan (Canada) of any medical information in my file including, but not limited to, copies of all consultation reports, clinical notes, test results and hospital records, for the purposes of administering the Special Disability Benefit and assessing my claim.

Member's Signature _____ Date _____/_____/_____
Day Month Year

PART 2: ATTENDING PHYSICIAN'S STATEMENT

1. History

a. Date symptoms first appeared or accident happened (D/M/Y)	b. Date patient ceased work because of current condition (D/M/Y)	c. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No
d. Has patient ever had same or similar condition? ☐ No ☐ Unknown ☐ Yes – Please state and describe:		e. Is condition considered chronic? ☐ No ☐ Yes - What precipitated absence from work?

f. Names and specialties of other treating physicians:

2. **Diagnosis** (including any complications)
Please include all relevant consultation reports and test results

a. Primary:

b. Additional conditions or complications which might affect duration of absence from work:

c. Subjective Symptoms:

d. Objective signs (including results of current x-rays, EKG's or laboratory data, and any relevant clinical findings):

3. Physical Impairment

What physical limitations affect the claimant's ability to work (e.g. limitation with respect to lifting, carrying, bending, walking, standing)?

4. Cognitive / Mental Impairment (if applicable)

(i) How does patient's cognitive or mental impairment affect ability to work?	
(ii) What is the DSM V diagnosis?	
(iii) Has there been a psychiatric referral? □ No □ Yes – date of first appointment (D/M/Y)	(iv) Do you believe the patient is competent to endorse cheques and direct the use of proceeds thereof? □ Yes □ No

5. Cardiac (if applicable)

a. Functional capacity (American Heart Association) □ Class 1 (no limitation) □ Class 2 (slight limitation) □ Class 3 (marked limitation) □ Class 4 (complete limitation)	b. Blood pressure (last 2 visits) Systolic Diastolic - -

6. Treatment

a. Date of first visit (D/M/Y)	b. Date of latest visit	c. Frequency of visits □ Weekly □ Monthly □ Other (specify)
d. Nature of treatment (including surgery, physiotherapy and medications prescribed if any)		

7. Progress

Since Diagnosis has the patient:

□ Recovered □ Improved □ Not Improved □ Retrogressed

8. Prognosis

Do you think that your patient will ever be able to return to work at full capacity?

□ No □ Yes, state approximate date (D/M/Y)

9. Remarks – Please provide comments and further details which you feel would be helpful.

Name of Attending Physician (please print)	**Specialty**	**Telephone No.** _____-_____-_____
Address Number Street	**City**	**Province Postal Code**
Signature	**Date (D/M/Y)**	

PRIVACY STATEMENT: The Plan will collect, maintain and communicate only the Personal Information considered necessary for the administration of the Plan. Personal Information will be protected pursuant to the relevant privacy legislation. The Plan may use and exchange information with relevant persons or organizations (unions, health professionals, institutions, investigative agencies, insurers, re-insurers, regulators, actuaries, legal counsel, etc.) in order to manage the Plan and entitlement to the benefits of the Plan. Questions related to the Privacy Policy of the Plan should be directed to the Plan Administration Office.