Centre intégré
universitaire de santé
et de services sociaux
de l'Est-de-
l'île-de-Montréal
Québec

Health and safety Department
7401, Hochelaga Street, Montreal (Quebec), H1N 3M5
Telephone: 514 251-4000, ext. 4006
Fax : 514 251-7348
email : sante_gestion.cemtl@ssss.gouv.qc.ca

SALARY INSURANCE CLAIM

SECTION A : Identification (to be completed by salaried employee)

LAST NAME: _____ **FIRST NAME :** _____ **EMPLOYEE NO.:** _____

E-MAIL: _____

DATE OF BIRTH : ___Y___/__M___/__D___ **TELEPHONE NO.** ( ) _____

DEPARTMENT : _____ **JOB TITLE** : _____ **SHIFT**: _____

NAME OF IMMEDIATE SUPERIOR : _____ **STATUS : FT** ☐ **PT** ☐ **TEMP** ☐

NAME OF YOUR HEALTH AND SAFETY ADVISOR : _____ **EXT. :** _____

AUTHORIZATION OF SALARIED EMPLOYEE*

I declare that the above information is accurate and hereby authorize my healthcare professionals as well as authorized representatives of hospitals or clinics to release relevant information regarding my health condition, disability, or period of absence from work as described herein to my employer, my employer's commissioned representative, or my employer's salary insurance consulting department.

SIGNATURE : _____ **DATE :** _____

*Processing of request can be delayed if salaried employee does not give authorization.

GENERAL INFORMATION FOR CLAIMANT AND TREATING PHYSICIAN

DEFINITION OF DISABILITY

TO BE ELIGIBLE FOR SALARY INSURANCE BENEFITS, THE SALARIED EMPLOYEE MUST PROVE THAT HIS OR HER MEDICAL CONDITION MEETS ALL OF THE FOLLOWING CRITERIA:

1. THIS DISABILITY IS THE RESULT OF DISEASE, ACCIDENT, COMPLICATION OF PREGNANCY, OR CONDITION RELATING TO FAMILY PLANNING OR ORGAN OR BONE MARROW DONATION

AND

2. THE SALARIED EMPLOYEE IS RECEIVING MEDICAL ATTENTION FOR THIS DISABILITY

AND

3. THE SALARIED EMPLOYEE IS **TOTALLY UNABLE** TO ACCOMPLISH THE USUAL TASKS REQUIRED IN THE PERFORMANCE OF HIS OR HER DUTIES, OR OF ANY SIMILAR DUTIES OFFERED BY THE EMPLOYER AND INVOLVING EQUIVALENT COMPENSATION.

DISABILITY REHABILITATION OR PROGRESSIVE RETURN TO WORK

AFTER RECEIVING APPROVAL FROM THE APPROPRIATE AUTHORITY AND SUBJECT TO THE PROVISIONS IN COLLECTIVE AGREEMENTS, A SALARIED EMPLOYEE CAN QUALIFY FOR A REHABILITATION PERIOD WHILE CONTINUING TO BE SUBJECT TO THE SALARY INSURANCE PLAN.

PLEASE NOTE THAT THIS DOCUMENT IS SOLELY OF AN INFORMATIVE NATURE, AND THAT IT DOES NOT REPLACE OR IN ANY CASE ADD TO PROVISIONS IN COLLECTIVE AGREEMENTS IN EFFECT WITHIN THE PUBLIC OR PARAPUBLIC SECTORS.

Revised on September, 12, 2017

SALARY INSURANCE CLAIM

LAST NAME : _____ **FIRST NAME** : _____ **EMPLOYEE NO** : _____

Date of 1st consultation for this disability: ___Y___/__M___/__D__

SECTION B: Medical report (to be completed by TREATING PHYSICIAN)

DIAGNOSIS

Principal: _____

_____

_____

Secondary:: _____

_____

_____

CLASSIFICATION ACCORDING TO DSM-IV MULTIAXIAL SYSTEM

Axis I _____
(Clinical psychiatric disorders)

Axis II _____
(Personality disorders, substance or gambling addiction, alcoholism)

Axis III_____
(General medical conditions)

Axis IV _____
(Psychosocial and environmental problems, work problems)

Axis V _____
(Global assessment of functioning scale)

MEDICAL FOLLOW-UP

Was this person referred to a specialist? Yes □ Name and specialization : _____

Consultation results:: _____

☐ **Diagnostic examinations** Specify : _____ Results : _____

☐ **Hospitalization** From : _____ To: _____

☐ **Surgery** Specify : _____ Date : _____

☐ **Physiotherapy / occupational therapy** Starting date : _____ Frequency : _____

☐ **Psychotherapy** Starting date : _____ Frequency : _____

☐ **Medication** Specify : _____ Dosage : _____

_____ Dosage : _____

☐ **Other** Specify : _____

PLAN FOR RETURN TOWORK

Return to regular duties : ___Y___/__M___/__D__

☐ Progressive return to work in original position From : _____ To : _____

Hours or days per week : _____

☐ Temporary assignment (light duties) From : _____ To : _____

Hours or days per week : _____

Medical restrictions : _____

INTERRUPTION OF WORK

Specify medical reasons making salaried individual totally unable to fulfill his or her duties or other duties offered by employer :

_____

_____

Approximate duration of disability :

Number of weeks: _____ Number of months _____ Approximate date of return to work : ____/____/____

Is this incapacity to perform original duties permanent and total? Yes ☐ No ☐

Have you completed the following documents: RRQ ___/___/___ SAAQ ___/___/___ CNESST ___/___/___ IVAC ___/___/___

Date of next appointment : ___Y___/__M___/__D__

PHYSICIAN INFORMATION

_____	_____	_____
PHYSICIAN'S NAME (please print)	Address	License Number
_____	_____	
PHYSICIAN'S SIGNATURE (stamp not accepted)	Telephone	
_____	_____	___Y___/__M___/__D__
SPECIALIZATION	Fax	DATE

Revised on September, 12, 2017