Attending Physician's Statement (APS) - GHC

This information will be used to assess your patient's claim for disability benefits. Please complete the form and send it to the confidential email or fax, attention of **Cowan Benefits Ltd., Return to Health® Email:** rthclient.service@cowangroup.ca **Fax:** 1-866-508-4111

Section A: Employee Information and Authorization (to be completed by Employee/Associate)		
First Name:	Last Name:	Date of birth: MM|DD|YYYY
Address:		
Phone Number:	Personal Email:	
Employer Name:	Employer Location/Division:	
Job Title:	Are you currently employed in any capacity? Yes ☐ No ☐ If yes, explain:	

Employee consent (to be completed by the employee):

The information on this form is being collected by Cowan Benefits Ltd. (Cowan) benefits under the plan and for facilitating my early and safe return to work including accommodation as may be required by statute. I authorize my treating medically qualified health care professional identified in Section D to provide Cowan with the following information relative to my claim. I also authorize Cowan to collect, use and disclose my personal and health information to a third-party claim administrator, insurer, for the purpose of facilitating the transition of my claim to a short-term disability and/or long-term disability plan. Medical information will be kept confidential by Cowan and will only be provided to my employer as permitted or required by law. It is understood that my employer will be notified concerning my eligibility for benefits and will be provided with information relevant to my return to work and accommodation. I agree that this authorization is valid throughout the duration of my claim including the resolution of an appeal review. I agree that a photocopy of this authorization or electronic version is valid as the original. I consent and agree that if I choose to provide this form electronically, I understand that by typing my name in the signature box I am signing this form, which has the same effect as if I had provided a handwritten signature.

Employee's Signature: **X**	Date (MM/DD/YYYY)

Section B: Attending Physician/Nurse Practitioner/Specialist Note: If you feel your patient can participate in a modified or gradual return to work, please complete all Sections. Otherwise, please complete Section B and D.	
Please identify the general nature of the illness or injury:	
Is the length of absence within the normal convalescent period (NCP) for this type of illness or injury? Yes ☐ No ☐	
If the length of absence is beyond the NCP, are there other medically supported, complicating factors affecting your patient's recovery? Yes ☐ No ☐	
Symptoms began or accident happened on: _____ MM|DD|YYYY	Date of first visit for this condition: _____ MM|DD|YYYY
Date of most recent examination: _____ MM|DD|YYYY	Date of next scheduled visit: _____ MM|DD|YYYY
Date first unable to work: _____ MM|DD|YYYY	

SYMPTOMS/OBJECTIVE FINDINGS

Did you undertake an objective medical assessment that supports the illness/injury? Yes ☐ No ☐

Is your patient capable of working at his/her own occupation, meaning is he/she able to perform the regular duties pertaining to his/her occupation? Yes ☐ No ☐

Employee Name: **Employer:**

TREATMENT

Is the illness treatable? Yes ☐ No ☐

Is your patient participating in and compliant with treatment? Yes ☐ No ☐ Unknown ☐

If 'NO', why not?

PROGNOSIS

Estimated date of return to full-time, full duties at work: _____

MM|DD|YYYY

How does the illness/injury impact work?

How would working impact the employee's recovery?

With modifications would the employee be able to return to work at an earlier date? Yes ☐ No ☐

If yes, provide estimated date: _____

Section C: ACCOMMODATION – Please complete if you feel your patient can participate in modified or gradual work. This information will be compared to the required job duties in an effort to assist with a modified and/or gradual return to work.

Please Check all that apply ✓	Restricted	Not Restricted	If restricted, outline specific limitations and duration (temporary/permanent)
PHYSICAL:			
Sitting	○	○	
Standing	○	○	
Walking	○	○	
Kneeling/crouching/squatting	○	○	
Bending/twisting	○	○	
Climbing stairs/ladders	○	○	
Push/pull	○	○	
Two-handed carrying	○	○	
One-handed carrying	○	○	
Reaching forward	○	○	
Reaching overhead	○	○	
Gripping/grasping	○	○	
Lifting floor to waist	○	○	Max lb/kg
Lifting waist to shoulder	○	○	Max lb/kg
Lifting above shoulder	○	○	Max lb/kg
COGNITIVE:			
Concentration/attention	○	○	
Memory	○	○	
Multi-tasking	○	○	
Planning/Problem solving	○	○	
Decision Making/judgment	○	○	
Communication	○	○	
Interaction with public	○	○	
Cooperation with co-workers	○	○	
Conflict resolution	○	○	
Emotional regulation	○	○	
Motivation/energy levels	○	○	

Employee Name: **Employer:**

RETURN TO WORK PLAN – Please provide any additional return to work recommendations, including the duration of the program.

Section D: Attending Physician/Specialist

Name:	License No.
Telephone:	Fax:
Physician's Signature: **X**	Date:

The completed form may be securely faxed, e-mailed or mailed to the following address:

Cowan Benefits Ltd., Return to Health®
225 King George Road, Brantford ON, N3R 7N7
Email: rthclient.service@cowangroup.ca
Fax: 1-866-508-4111