Centre intégré
de santé
et de services sociaux
de la Côte-Nord
Québec

SALARY INSURANCE CLAIM

NAME:	EMPLOYEE #:

PART A : Medical Report (to be completed by the TREATING PHYSICIAN)

DIAGNOSIS

Principal : _____

_____

_____

Secondary : _____

_____

_____

ACCORDING TO THE MULTIAXIAL CLASSIFICATION OF THE DSM-IV

Axe I _____
(Clinical psychiatric problems)

Axe II _____
(Personality disorder, addictions, alcoholism, gambling)

Axe III _____
(Physical illnesses)

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

Axe V Beginning of treatment: _____ Currently: _____
(Global functional assessment)

MEDICAL FOLLOW-UP

This person was referred to a specialist? Yes ☐ Specialization: _____

Results of the consultation: _____

☐ DIAGNOSTIC EXAMANITIONS Specify: _____ Results: _____

☐ HOSPITALIZATION From: _____ To: _____

☐ SURGERY Specify: _____ Date: _____/_____/_____

☐ PHYSIO/OCCUPATIONAL THERAPY Starting date: _____ Frequency: _____

☐ PSYCHOTHERAPY Starting date: _____ Frequency: _____

☐ MEDICATION Specify: _____ DOSAGE: _____

☐ OTHER Specify: _____

Collaboration of the patient with his/her treatment Excellent ☐ Average ☐ Mediocre ☐

PLAN FOR RETURN TO WORK

☐ Return to regular duties Date: _____/_____/_____

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

Means: _____

☐ Light work No ☐ Yes ☐ (complete the reverse side) Means: _____

From: _____ To: _____

INTERRUPTION OF WORK

Date of the1st consultation for this disability: _____/_____/_____

Identify the medical reasons that the employee is totally unable to hold his/her job or any job offered by the employer, specify the degree of seriousness for each of them (L = light, A = average, I = intense):

Signs	L	A	I	Symptoms	L	A	I
_____	☐	☐	☐	_____	☐	☐	☐
_____	☐	☐	☐	_____	☐	☐	☐
_____	☐	☐	☐	_____	☐	☐	☐

Approximate duration of the disability : Number of weeks _____ Number of months _____ Approximate date of return to work _____/_____/_____

Would it be a total and permanent disability for his/her job? Yes ☐ No ☐

Have you completed the documents: RRQ ☐ _____/_____/_____ SAAQ ☐ _____/_____/_____ CSST ☐ _____/_____/_____ IVAC ☐ _____/_____/_____

Date of the next appointment _____/_____/_____

IDENTIFICATION OF THE PHYSICIAN

_____ _____ _____

NAME OF THE PHYSICIAN (PRINT IN CAPITAL LETTERS) ADDRESS LICENSE MEMBER

_____ _____

_____/_____/_____

SIGNATURE OF THE PHYSICIAN (STAMP IS NOT ACCEPTED) TELEPHONE DATE

_____ _____

PHYSICIAN'S SPECIALITY Fax N°

PART A: Medical Report (to be completed by the TREATING PHYSICIAN) continue

FUNCTIONALS LIMITATIONS TO RESPECT FOR LIGHT TASKS (check mark the appropriate tasks)

The worker must avoid:

- ☐ Handling loads with the upper limbs _____ of more than _____
- ☐ Handling by twisting, flexing or extending the torso;
- ☐ Pulling or pushing objects or equipment;
- ☐ Standing still;
- ☐ Repetitive movements: _____
- ☐ Walking more than (duration, frequency or distance): _____
- ☐ Raising upper limb _____ higher than: _____

PROPOSITIONS FOR LIGHT TASKS (check mark the appropriate tasks)

The worker can:

- ☐ Help with mobilisation
- ☐ Greet users, visitors and employees
- ☐ Helps with snacks, feeding and other leisure activities
- ☐ Supervise and exchange with beneficiaries, private service
- ☐ Light cleaning tasks (cleaning and replacing supplies, placing personal items in dressers, dusting, disinfecting, folding clothes.)
- ☐ Assistance with light hygiene (teeth, shaving, cutting nails, etc.)
- ☐ Storing items (preparing food portions, stocking shelves and carts, labelling, etc.)
- ☐ Office tasks (telephone, photocopies, filing, updating documents, etc.)
- ☐ Perform various (light) commissions in the building
- ☐ Participate in meetings and training
- ☐ Clinical work (teaching, light care, etc.)
- ☐ All other tasks that respect the limitations mentioned above.

Additional comments:

PARTIE B – IDENTIFICATION (to be completed by the employee)

LAST NAME: **FIRST NAME:** **EMPLOYEE NUMBER:**

DATE OF BIRTH: **TELEPHONE: ( )**

NAME OF IMMEDIATE SUPERIOR:

I declare the above-mentioned information to be exact and authorize the physicians, health care professionals (psychologists, social workers, physiotherapists, etc.), authorized representatives of the hospitals or clinics to provide to my employer or to the authorised representative and to the support counselling service in salary insurance all of the necessay information relating to my health condition and disability or the period of absence described in this claim.

Signature ** : _____ **Date:** _____

**** The absence of authorization by the employee can cause a delay in the processing of the application**

DISABILITY DEFINITION

TO BE ELIGIBLE FOR SALARY INSURANCE BENEFITS, THE EMPLOYEE MUST DEMONSTRATE THAT HIS/HER MEDICAL CONDITION CORRESPONDS TO THE THREE CRITERIA OF THE FOLLOWING DEFINITION:

CRITERIA 1

- STATE OF DISABILITY RESULTING FROM A DISEASE OR AN ACCIDENT OR A PREGNANCY COMPLICATION OR A CONDITION RELATED TO FAMILY PLANNING OR AN ORGAN DONATION

AND **CRITERIA 2**

- WHO IS THE SUBJECT OF A MEDICAL FOLLOW-UP

AND **CRITERIA 3**

- THAT RENDERS THE EMPLOYEE TOTALLY INCAPABLE OF PERFORMING HIS/HER USUAL WORK TASKS OR ANY OTHER SIMILAR EMPLOYMENT OFFERED BY THE EMPLOYER AND WITH A SIMILAR REMUNERATION.