VIRTUAL MEDICAL DIRECTOR Employer Case Initiation Form

Date _____



457 Lakeshore Drive, Dorval, QC, H9S 2A9 P 1.877.37.EXTRA (373.9872) F 514.526.4521, E advocate@medextra.com

| Contact Perso | n | | | |
|------------------|-------------------------|-------------------------|--------------------|---------------------------|
| Phone # | | | | |
| Email | | | | |
| EMPLOYEE | INFORMATION | | | |
| Name | | | DOB/Age | |
| Email | | | Phone # | |
| Department | | | Occupation | |
| Years in Comp | any | | Year started o | current position |
| PRESENT WO | ORK STATUS | | | |
| At work | Full time \square | Part time □ | | Work from home \square |
| Off work | Sick leave \square | Paid/Admin. L | _eave □ | EI 🗆 |
| Limitations | No □ | Yes □ | | |
| Disability Sta | atus LTD 🗆 STD 🗆 | Pending \square | Approved \square | Not yet applied \square |
| CURRENT IS | SUE – REASON FOR AB | SENCE | | |
| Accident □ | Sickness ☐ Ho | spitalization \square | | |
| Last day wor | ked (YYYY-MM-DD) | | | |
| WORK PER | FORMANCE/EVALUATI | ON PAST YEAR | | |
| Above Avera | ge □ Average □ | Below Averag | ge □ | |
| Stable \square | Deteriorating \square | Improving \Box | | |
| Previous abs | ences No Yes | ☐ (please attach | ٦) | |
| ORIFCTIVE | CASE OVERVIEW | | | |



VIRTUAL MEDICAL DIRECTOR Employee Authorization

LOCATION OF MEDICAL RECORDS / NAME AND COORDINATES OF PHYSICIANS:

| Medical Solutions Médicales | |
|---|---|
| 457 Lakeshore Drive, Dorval, QC, H9S 2A | 9 |
| P 1.877.37.EXTRA (373.9872) | |

F 514.526.4521 E advocate@medextra.com W https://medextra.com/portal/

| MedExtra's role in the provision of the Medical Director Program is to clarify and understand your condition, and to evaluate the potential impact this health event has on your fitness for work and for return-to-work planning. Information regarding diagnosis and treatment will not be transmitted to your employer. INFORMATION RELEASE The undersigned, consent to oral, written and electronic communication and information exchange regarding personal information and health condition between MedExtra and any health care practitioners or licensed physici high have records or reports related to my current absenteeism/health/rehabilitation, and any independ evaluators, service providers, agents and consultants working with MedExtra, including my long-term disability benefit paths provided the purpose of this consent, and the exchange of information, is to assess the prognosis for return to work, my disability apabilities and limitations regarding return to work, and any workplace accommodations. This consent pertains to the current referral to MedExtra for services and may include the results of consultations issessments obtained during the time I have been absent from work. MedExtra may use the services of ndependent evaluator or service provider to assist with this determination. The undersigned, hereby authorize and direct you to furnish MedExtra with all the information, opinions and repulation that they may request from you, as necessary, including copies of my files, medical charts, reports and test results and other documentation relating to me. As well, your full co-operation with MedExtra is respectfully requested. A photocopy or facsimile of this authorization shall be as valid as the original. This consent is valid for the purposes set outerein. It may be withdrawn at any time with written notification to MedExtra. | e purpose of this consent, are purpose of this consent, are pabilities and limitations regals consent pertains to the obsessments obtained during ependent evaluator or service the undersigned, hereby autout they may request from your documentation relating to thotocopy or facsimile of this rein. It may be withdrawn at a | current referral to MedExtra for services and may include the g the time I have been absent from work. MedExtra made provider to assist with this determination. In thorize and direct you to furnish MedExtra with all the information, as necessary, including copies of my files, medical charts, repeto me. As well, your full co-operation with MedExtra is respect to a suthorization shall be as valid as the original. This consent is valuany time with written notification to MedExtra. | e results of consultations by use the services of mation, opinions and reports and test results and fully requested. |
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| ADDRESS | MEDICARE CARD # | | |
| | DATE OF BIRTH | | |
| NAME | ADDRESS | | |
| | NAME | | |
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