VIRTUAL MEDICAL DIRECTOR
Employer Case Initiation Form

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

Date ______________________________

1) COMPANY NAME ______________________________

Contact Person ______________________________

Phone # ______________________________

Email ______________________________

2) EMPLOYEE INFORMATION

Name ______________________ DOB/Age ______________________

Email ______________________ Phone # ______________________

Department ______________________ Occupation ______________________

Years in Company ______________________ Year started current position __________

PRESENT WORK STATUS

At work	Full time ☐	Part time ☐	Work from home ☐
Off work	Sick leave ☐	Paid/Admin. Leave ☐	EI ☐
Limitations	No ☐	Yes ☐	
Disability Status	LTD ☐ STD ☐	Pending ☐ Approved ☐	Not yet applied ☐

CURRENT ISSUE – REASON FOR ABSENCE

Accident ☐ Sickness ☐ Hospitalization ☐

Last day worked (YYYY-MM-DD) ______________________

WORK PERFORMANCE/EVALUATION PAST YEAR

Above Average ☐ Average ☐ Below Average ☐

Stable ☐ Deteriorating ☐ Improving ☐

Previous absences No ☐ Yes ☐ (please attach)

OBJECTIVE CASE OVERVIEW

MANDATE: What do you want from MedExtra? What are your expectations?

MedExtra
Medical Solutions Médicales

VIRTUAL MEDICAL DIRECTOR
Employee Authorization

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LOCATION OF MEDICAL RECORDS /
NAME AND COORDINATES OF PHYSICIANS:

____

____

____

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NAME	
ADDRESS	
DATE OF BIRTH	
MEDICARE CARD #	

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

I, the undersigned, consent to oral, written and electronic communication and information exchange regarding my personal information and health condition between MedExtra and any health care practitioners or licensed physicians which have records or reports related to my current absenteeism/health/rehabilitation, and any independent evaluators, service providers, agents and consultants working with MedExtra, including my long-term disability benefit payer.

The purpose of this consent, and the exchange of information, is to assess the prognosis for return to work, my disabilities, capabilities 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 or assessments obtained during the time I have been absent from work. MedExtra may use the services of an independent evaluator or service provider to assist with this determination.

I, the undersigned, hereby authorize and direct you to furnish MedExtra with all the information, opinions and reports that they may request from you, as necessary, including copies of my files, medical charts, reports and test results and all 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 out herein. It may be withdrawn at any time with written notification to MedExtra.

Signed on (Date):	**at (City):**
By (Print name):	
Signature:	