VIRTUAL MEDICAL DIRECTOR
Employer Case Initiation Form

MedExtra
Medical Solutions Médicales
457 Lakeshore Drive, Dorval, QC, H9S 2A9
Phone: 1-877-373-9872
Fax: 514-526-4521
Email:initiation@medextra.com

Date _____

COMPANY NAME: _____

Contact Person _____
Phone # _____
Email _____

EMPLOYEE NAME: _____

Age / DoB _____ Employee since _____
Occupation _____ Years in current position _____
Phone _____ Email _____

PRESENT WORK STATUS

At work	Full time ☐	Part time ☐	Work from home ☐	Work in office ☐	Hybrid work ☐
Limitations	No ☐	Yes ☐	If yes, kindly provide modified work description		
Progressive RTW schedule	No ☐	Yes ☐	If yes, kindly provide modified schedule		
Type of absence	Workplace Accident ☐		Personal Sickness ☐		Hospitalization ☐
Last day worked					
Disability Status	LTD ☐	STD ☐	EI ☐	Pending ☐	Not yet applied ☐

WORK PERFORMANCE: How would you describe the latest performance review?

Above Average ☐ Average ☐ Below Average ☐

Has there recently been a workplace conflict? No ☐ Yes ☐

If yes, please provide a brief description.

OBJECTIVE CASE OVERVIEW

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

Please attach:

- Job description
- Medical certificates (“doctor’s note”)
- Attendance record
- Attending Physician Statements

Employee Authorization and Consent - MedExtra

What You're Agreeing To

By signing below, related to your current or recent absences, (including workplace injury claims) or accommodation needs, you are consenting to:

1) Your healthcare provider(s) to share with MedExtra your relevant medical records, reports, test results, and any other information.
2) Your healthcare provider(s) to cooperate with Medextra in a timely manner in providing additional information related to my absence or accommodation requests
3) MedExtra communicating with and receiving medical information from your treating physicians and other health professionals involved in your care or rehabilitation.

When You're Being Asked to Sign This

This consent form relates to your time away from work related to a personal condition or workplace injury claim :

- You've been off work for more than 10 days
- You've had repeated absences totaling more than 10 days in the past 12 months
- You're requesting workplace accommodations.

Why You're Being Asked to Sign This

As your employer's Medical Director, we may require additional health-related information to understand and assess:

1) The nature of your illness or injury
2) The expected return-to-work date and/or the next medical visit
3) Your ability to perform your duties
4) What you may need to safely return, such as accommodations or modified duties

The Privacy of Your Medical Records is Protected

Your personal and health information stays confidential and is only used for the reasons listed above.

MedExtra will not send any of your medical information to your employer or any party managing salary continuance or short- or long-term disability insurance or employment insurance supplements without your separate, express written permission.

Confidentiality of Information and Communications

All information exchanged between MedExtra and your treating healthcare providers is strictly confidential to be used only for the purposes outlined in this consent form.

To prevent inappropriate use, misuse, misinterpretation of the information or the misinterpretation of the nature of the confidentiality of the information, no verbal discussions, written correspondence, electronic messages, forms and/or questionnaires, reports, assessments or any other documents initiated, requested or exchanged by MedExtra and any of your treating healthcare providers shall be disclosed to any other third party without your express written permission and that of MedExtra.

This includes employers, disability managers, providers of short- or long-term salary insurance or salary continuance, employment insurance supplements, third-party administrators or providers of any supplemental group insurance benefits.

Other Details

From time to time I understand that my doctor will be asked to use their best efforts to cooperate with MedExtra and to provide, in a timely fashion, the requested medical records and completed MedExtra forms or questionnaires.

The information on the completed questionnaire will be used solely by MedExtra to understand the evolving state of my condition, the barriers to return to work and the prognosis for return to work. I respectfully request to my doctor that they cooperate fully and in a timely manner in responding to MedExtra.

A photocopy, fax, or digital version of this form is just as valid as the original. Your consent can be withdrawn at any time by writing to MedExtra.

Language Declaration (Charter of the French Language)

You acknowledge and agree that this form and all related documents are in English because you have requested it. "The parties have requested that this Agreement and all related documents be drawn up in English only. *Les parties ont exigé que le présent contrat et tous les documents qui s'y rapportent soient rédigés en anglais seulement*."

I understand and agree to the above.

Employee Signature:	MedExtra Representative Signature
_____	_____
Printed Name:	Printed Name:
_____	_____
Date (YYYY/MM/DD):	Date (YYYY/MM/DD):
_____	_____

Name: _____

Date of Birth: _____

Medicare #: _____

Address: _____

Clinic and physician where my medical records are located, name of clinic where other healthcare professional records are located: Psychology, physiotherapy or others:

1) _____

2) _____

3) _____

4) _____

5) _____