



Sections 1 & 2 must be completed for claim to be considered

SECTION 1 (to be completed by the Teacher)

Name _____	Professional Number _____	Phone Number _____
School _____	Date & Time of Injury _____	
Specific Location of Accident _____	Witness(es) to Injury _____ _____	
Have you lost time from work? Yes <input type="checkbox"/> No <input type="checkbox"/> <u>If yes:</u> Date of 1 st missed day (or part thereof) _____	Date SIP Form was completed _____	
Brief description of how injury occurred (part of body injured, anything that may have contributed to the injury) _____ _____ _____		
Describe what you were doing at the time _____ _____		
TEACHER: I authorize my health care providers to disclose to my employer all medical information related to my abilities and limitations to perform the duties of my position in respect of this claim.		
Teacher's Name (signature) _____	Current Assignment _____	
Date _____		
Home Address _____		
PRINCIPAL:		
<input type="checkbox"/> I have reviewed the information provided		
<input type="checkbox"/> I have reviewed the information and wish to provide additional information (please attach additional written information)		
Principal's Name (signature) _____	Date _____	



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SECTION 2 (to be completed by the Physician)

What is the nature and extent of your patient's functional impairment?

To what extent is this impairment related to the injury that is the subject of this claim?

To what degree is your patient's current functional impairment related to a pre-existing injury, illness or condition?

Do you believe this injury is likely to result in a permanent impairment?
 Yes No

Additional Information: _____

Has your patient been referred to a physiotherapist, chiropractor or specialist?

Dates you attended the patient	Visit #3 _____
Visit #1 _____	Visit #4 _____
Visit #2 _____	Visit #5 _____

PHYSICIAN: The information provided in this document is true and based on my examination of the patient.

_____ Physician's Name (print)	_____ Work Phone Number	_____ Date
_____ Physician's Signature	_____ Clinic Mailing Address	