

① Family name: \_\_\_\_\_ ② Given name: \_\_\_\_\_  
 ③ Contract no.: \_\_\_\_\_ ④ Certificate number: \_\_\_\_\_  
Group or policy no. \_\_\_\_\_ Y Y Y Y M M D D  
 ⑤ Date of birth: \_\_\_\_\_

**Declaration of the attending physician (Complete in block letters and give to the patient)**

**1. Diagnosis**

1.1 Principal: \_\_\_\_\_  
 1.2 Secondary: \_\_\_\_\_  
 1.3 Complications: \_\_\_\_\_  
 1.4 For the illnesses or associated symptoms diagnosed, has the patient previously:  
 a) received medical treatments  b) consulted another physician  c) taken drugs  d) been hospitalized  e) undergone examinations   
 Specify the periods: \_\_\_\_\_  
 1.5 Is the disability related to: an accident  an illness  an occupational accident  an automobile accident   
Y Y Y Y M M D D  
 Date of the event: \_\_\_\_\_  
 a pregnancy No  Yes  Y Y Y Y M M D D  
 a preventive withdrawal from work No  Yes  Scheduled date of delivery: \_\_\_\_\_  
 1.6 Describe functional limitations that prevent the patient from carrying out professional duties or usual activities.  
Y Y Y Y M M D D  
 At the beginning of disability \_\_\_\_\_ Currently \_\_\_\_\_

**2. Treatment**

2.1 Drugs – name – dosage: \_\_\_\_\_  
 2.2 Has the patient undergone or will undergo:  
 a) examinations or tests No  Yes  Specify: \_\_\_\_\_  
 b) surgery No  Yes  Day surgery  Type: \_\_\_\_\_  
Y Y Y Y M M D D  
 Surgical procedure: \_\_\_\_\_ Date: \_\_\_\_\_  
 c) other treatments No  Yes  Specify: \_\_\_\_\_  
 d) hospitalization: from \_\_\_\_\_ to \_\_\_\_\_ Name of hospital: \_\_\_\_\_  
 e) a short stay under observation No  Yes  Number of hours: \_\_\_\_\_

**3. Follow-up and prognosis**

3.1 Date of first consultation for this disability: Y Y Y Y M M D D \_\_\_\_\_ Next consultation: Y Y Y Y M M D D \_\_\_\_\_  
 3.2 Dates of other consultations: \_\_\_\_\_ Follow-up frequency: \_\_\_\_\_  
 3.3 Referral to another physician: No  Yes  Name of physician: \_\_\_\_\_  
 Specialty: \_\_\_\_\_  
 3.4 Approximate duration of disability: No. of days \_\_\_\_\_ No. of weeks \_\_\_\_\_ Unspecified  or date of return to work Y Y Y Y M M D D \_\_\_\_\_  
 3.5 How long before the patient will be able to return to work? No. of days \_\_\_\_\_ No. of weeks \_\_\_\_\_  
 part-time  full-time  gradual return  Specify: \_\_\_\_\_

**4. Questions specific to the contract**

4.1 During the last five years, has the patient consulted or been treated by a physician or another practitioner, or taken drugs prescribed by a physician for one of the following illnesses or conditions: cancer or tumor, diabetes, hypertension, Crohn's disease, ulcerative colitis, hepatitis, heart diseases or blood vessel disorders, drug addiction or alcoholism, nervous or mental disorders, pulmonary disorders, renal or urinary problems, cerebral or neurological problems, disorders related to the spine, illnesses related to AIDS? Has the patient undergone an analysis showing the presence of HIV antibodies?  
 No  Yes  **If yes, please indicate the following information:**

Illnesses	Dates	Results	Periods of hospitalization	When was the patient informed of this illness?

4.2 \_\_\_\_\_

**5. Identification of the physician**

5.1 Family name, given name: \_\_\_\_\_ Telephone: ( \_\_\_\_\_ )  
 5.2 License number: \_\_\_\_\_ Fax: ( \_\_\_\_\_ )  
 General practitioner  Specialist  Specify: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: Y Y Y Y M M D D \_\_\_\_\_

① Family name: \_\_\_\_\_ ② Given name: \_\_\_\_\_  
 ③ Contract no.: \_\_\_\_\_ ④ Certificate number: \_\_\_\_\_  
 Group or policy no. \_\_\_\_\_ ⑤ Date of birth: \_\_\_\_\_  
 Y Y Y Y M M D D

**Declaration of the attending physician (Complete in block letters and give to the patient)**

**1. Diagnosis**

1.1 Principal: \_\_\_\_\_  
 1.2 Secondary: \_\_\_\_\_  
 1.3 Current symptoms: \_\_\_\_\_  
 1.4 Degree of severity of all symptoms: Mild  Moderate  Severe  With psychotic elements   
 1.5 Does the interruption of work result from problems related to:  
 marital/family life  loss of employment or layoff  professional problems  
 personal or interpersonal problems  alcohol or drug abuse or gambling problems  
 other problems, specify: \_\_\_\_\_  
 1.6 For the illnesses or associated symptoms diagnosed, has the patient previously:  
 a) received medical treatments  b) consulted another physician  c) taken drugs  d) been hospitalized  e) undergone examinations   
 Specify the dates of previous episodes: \_\_\_\_\_

**2. Treatment**

2.1 Drugs – name – dosage: \_\_\_\_\_  
 2.2 Is the patient consulting: a psychiatrist No  Yes  a social worker No  Yes   
 a psychologist No  Yes  another health care provider No  Yes   
 If Yes, name of the caregiver consulted: \_\_\_\_\_  
 2.3 Hospitalization: from \_\_\_\_\_ to \_\_\_\_\_ Name of hospital: \_\_\_\_\_

**3. Follow-up and prognosis**

3.1 Date of first consultation for this disability: \_\_\_\_\_ Next consultation: \_\_\_\_\_  
 Y Y Y Y M M D D Y Y Y Y M M D D  
 3.2 Dates of other consultations: \_\_\_\_\_  
 3.3 Follow-up frequency: \_\_\_\_\_  
 3.4 Will the patient be referred to a psychiatrist? No  Yes  Name of physician: \_\_\_\_\_  
 Y Y Y Y M M D D  
 3.5 Approximate duration of disability: No. of days \_\_\_\_\_ No. of weeks \_\_\_\_\_ Unspecified  or date of return to work \_\_\_\_\_  
 3.6 How long before the patient will be able to return to work? No. of days \_\_\_\_\_ No. of weeks \_\_\_\_\_  
 part-time  full-time  gradual return  Specify: \_\_\_\_\_

**4. Questions specific to the contract**

4.1 During the last five years, has the patient consulted or been treated by a physician or another practitioner, or taken drugs prescribed by a physician for one of the following illnesses or conditions: cancer or tumor, diabetes, hypertension, Crohn's disease, ulcerative colitis, hepatitis, heart diseases or blood vessel disorders, drug addiction or alcoholism, nervous or mental disorders, pulmonary disorders, renal or urinary problems, cerebral or neurological problems, disorders related to the spine, illnesses related to AIDS? Has the patient undergone an analysis showing the presence of HIV antibodies?  
 No  Yes  If yes, please indicate the following information:  

Illnesses	Dates	Results	Periods of hospitalization	When was the patient informed of this illness?

 4.2 \_\_\_\_\_

**5. Identification of the physician**

5.1 Family name, given name: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_  
 5.2 License number: \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_  
 General practitioner  Specialist  Specify: \_\_\_\_\_  
 Y Y Y Y M M D D  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_