

## Physician's Certificate of Disability for Duty

Please send this form to the appropriate Disability Management Group by fax or by mail using the below address information

## For Sick Leave Benefits Program:

Manulife (Confidential) PO Box 400, STN Place-D'Armes Montreal QC H2Y 3141

Email: belldmg@manulife.com

Telephone: (514) 287-4393 \* (1-866) 364-4393 Fax: (514) 287-4394 (1-866) 364-4394

## For Workers Compensation (WCB) claims:

Workplace Injury Management Group (WIMG) Bell Canada (Confidential)

Alexandre G. Bell

Tour A, Floor 3

Verdun, (Quebec) H3E 3B3

Telephone: (514) 870-2975 \* (1-800) 228-7731 Fax: (514) 391-2272 \* (1-866) 391-2272

ame:					* ''	
Surname			Given			
esidence Address:						
	No.	Street		City/Town	Postal Cod	le
usiness Unit:						
ob Title:			Personnel No:	Date Absence began:		
					Day Month	Year
hysician's Name:						
ddress:						
nereby authorize t formation reques		physician to o	disclose to the Bell Disab	ility Management Group (DMG) and	d/or its designated	agent, the
normation reques	tea ill tills forfit.					
ate:		_ Signature o	of employee:			
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Physician's name	(Stamp	Print or	Type!	١
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## Physician's Signature

Address:	Telephone No:
	Date:

Note: The employee's interest with be best served by your prompt return of this form.