Bell MTS

Bell MTS Form 1109 (11/12/19)

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

Section 1: To be completed by the employee:

Name: _____
Surname Given Names/Initials

Residence Address: _____
No. Street City/Town Postal Code

Business Unit: _____

Job Title: _____ Personnel No: _____ Date Absence began: ____/____/____.
Day Month Year

Physician's Name: _____

Address: _____

I hereby authorize the above named physician to disclose to the Bell Disability Management Group (DMG) and/or its designated agent, the information requested in this form.

Date: _____ Signature of employee: _____

Section 2: Attending Physician's Report (Confidential)

The medical information contained on this form is for the confidential use of Manulife, on behalf of the Bell DMG, as the administrator of the Sick Leave program.

1. Date of first examination (present illness): ____/____/____ Date of most recent examination: ____/____/____.
   Day Month Year Day Month Year
2. Specify the nature of the illness or injury which has required the employee to remain off work: _____

   _____
3. Surgery: _____

   Date of operation: ____/____/____.
   Day Month Year
4. Is disability result of Illness Y / N Non-occupational injury Y / N Occupational injury or illness Y / N
5. When in your opinion, should the employee be able to return to work:
   a. To regular occupation: ____/____/____ b. to lighter occupation: ____/____/____.
   Day Month Year Day Month Year
6. Please provide details and the duration of any medical restrictions/limitations: _____

   _____

_____, M.D. _____, M.D.

(over)

Physician's name (Stamp, Print or Type)

Physician's Signature

Address: _____ Telephone No: _____

_____

_____ Date: _____

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