Éducation
Québec

USER GUIDE

DISABILITY MEDICAL REPORT
AND SALARY INSURANCE

Sections A and C: Identification of Employee and Employer

Sections A and C must be completed by the employer. These sections are for collecting information on the employee and the employer.

Note on the name of the employer's representative:
The signatory must be the person designated and authorized by the employer to contact the representative of Services-conseils aux gestionnaires des réseaux de l'éducation.

Section B: Attestation and Authorization of Employee

This section must be completed and signed by the employee. If he or she refuses to sign it, the employer could reject his or her application for the payment of salary insurance benefits.

Section D: Medical Report

The employee must ensure that this section of the form is completed by a physician who is a member of the Corporation professionnelle des médecins du Québec (CPMQ) and who must indicate, among other things, the diagnosis, the date on which the disability began, and the expected date of return to work. The physician must indicate whether there is any functional disability. He or she must also indicate whether there will be a possibility of gradual return to work.

Subsection 3) A):

"Date of end of period agreed to by employer": The employer must enter the date of the end of the disability period to which he or she agreed. This date indicates to the attending physician when the employer will assess whether the disability is prolonged.

Should the disability be prolonged, the physician must describe the medical reasons or complications in support thereof. The costs related to the report are assumed by the employee, unless stipulated otherwise in the collective agreements or working conditions.

If necessary, the employer can forward the duly completed form to the person responsible for his or her salary insurance files at the Services-conseils aux gestionnaires des réseaux de l'éducation at the following address:

Services-conseils aux gestionnaires
des réseaux de l'éducation
Ministère de l'Éducation
150, boulevard René-Lévesque Est, 15e étage
Québec (Québec) G1R 5W8

Telephone: (418) 644-8803
Fax: (418) 646-5424

GENERAL INFORMATION

For information on a disability-related absence file, the person designated and authorized by the employer should contact the representative of the Services-conseils aux gestionnaires des réseaux de l'éducation who is responsible for this file.

Éducation Québec

DISABILITY MEDICAL REPORT
Salary Insurance

Section A: Identification of employee and employer (to be completed by the employer)

Identification of employee

Family name | First name

Social insurance number | Sex ☐ M ☐ F | Date of birth (Year Month Day)

Address | Province | Postal code

Date of beginning of disability (Year Month Day) | Job title

Status of employment ☐ Regular ☐ Other | Where applicable, indicate the date of end of employement (Year Month Day)

Identification of the employer

Employer's no. | Name of employer

Address

Representative of employer

Name (please print) | Area code Telephone no. Ext.

Signature | Area code Telephone no.

Note: Please complete Section C "Identification of the Employee", and indicate the "date of end of period agreed to by employer" in Subsection D, 3) A).

Section B: Attestation and Authorization of Employee (to be completed by employee)

Have you filed, or do you intend to file a claim concerning your present disability under a law administered by one of the following organizations? (If so, please check the appropriate box.)

☐ IVAC: Indemnisation des victimes d'actes criminels

☐ SAAQ: Société de l'assurance automobile du Québec

☐ CSST: Commission de la santé et de la sécurité du travail

☐ RRQ: Régie des rentes du Québec

I certify that the information contained in this report is accurate, and I authorize **the physicians and authorized representatives of hospitals** and **any other organizations concerned to provide the employer and Services-conseils aux gestionnaires des réseaux de l'éducation** with any pertinent information concerning my health condition or medical history with regard to the disability described in this report. Upon request, I will submit to the employer the supporting documents attesting to the treatment received from any other health professional for the said disability.

Signature | **Date** (Year Month Day) | Area code Home telephone no.

General Information Intended for the Attending Physician and the Employee Claiming Salary Insurance Benefits

Salary Insurance Plan

The costs related to the salary insurance plan in the education network are assumed in their entirety by the employer for the first 104 weeks of disability. This is a self-insurance plan to which the employee does not contribute.

While the employer is responsible for the payment of salary insurance benefits, he or she must ensure that the benefits are paid in accordance with the rules governing the collective agreements in force in the education network.

The employer may, if he or she deems it appropriate, require additional information in order to enable him or her to assess the eligibility of the claim, as well as any extension of the absence. He or she may refer an employee to a physician he or she may designate. Any cost related to a medical report, such as professional fees or additional information, are assumed by the employee, unless otherwise stipulated in the collective agreements or working conditions.

Definition of "Disability"

To be eligible for salary insurance benefits during a disability period, the employee must demonstrate that his or her medical condition meets the following criteria:

1. the state of incapacity **must result from an illness, accident, pregnancy complication** or **surgical procedure related to family planning**;
   AND
2. the illness (or accident) **necessitates medical care**;
   AND
3. the disability must render the employee **totally unable to perform the usual duties of his or her position,** or **any other similar position** calling for comparable remuneration.

Definition of "Functional Disability"

A functional disability or incapacity is any restriction resulting from an impairment which significantly limits the employee's ability to perform an activity. This indicates what the employee is no longer able to do.

Gradual Return to Work

Any employee may, after agreement with the employer, benefit from a period of gradual return to work during which he or she must be able to perform all of his or her duties according to the agreed proportion of time.

Note: This document is intended for information purposes only and does not, in any circumstances, replace or add to the definitions contained in the collective agreements in force in the education network.

Section C: Identification of the Employee

Name of employee

Social insurance number

Section D: Medical report (to be completed legibly by the physician)

1) DIAGNOSIS

Main illness causing present disability

In the case of a mental disorder, fill in the axis according to DSM IV.

Axis I

Axis II

Axis III

Axis IV

Assessment of illness: ☐ Serious ☐ Moderate ☐ Minor

Diagnostic code

Axis V

Diagnostic code

Secondary illness (if any)

Diagnostic code

First examination for this disability: Year Month Day

Frequency of visits

Pregnancy: EDC Year Month Day

Is this a serious complication? ☐ Yes ☐ No

Stay in hospital or clinic: Name

From: Year Month Day to: Year Month Day

Referral to a specialist (specify date of appointment) Year Month Day

Name of physician (specialty)

Result (or annex copy)

Brief report of specific pertinent tests: CSF, HB, ECG, EMG, CAT, MRI, AP (reading and date), etc.

2) TREATMENT

☐ None ☐ Medical: medication and dosage (date of beginning)

In the case of surgery, is the employee able to work while awaiting surgery? ☐ Yes ☐ No

☐ Surgical: nature and date of surgery

Therapy	Frequency	Name of professional or clinic
☐ Physiotherapy:		
☐ Psychotherapy:		
☐ Other (specify):		

3) DISABILITY – GRADUAL RETURN TO WORK

A) Disability (definition on previous page)

Indicate how the illness described above renders the employee unable to hold the position entered in Section A. Indicate the **functional disabilities** (definition on previous page).

Date of end of period agreed to by employer Year Month Day

If the absence is extended beyond the date of the period agreed to by the employer, describe the medical reasons or complications justifying the extention.

In your opinion, is the employee presently totally unable to perform the usual duties of **his or her position**? ☐ Yes ☐ No

Date of beginning of disability: Year Month Day

Expected date of return to work: Year Month Day

If undetermined, indicate the approximate date of end of absence: Year Month Day

Date of next appointment: Year Month Day

B) Gradual Return to Work (definition on previous page)

Could the employee return to work on a gradual basis? ☐ Yes ☐ No

If so, no. of days/wk and weeks? Days/wk Weeks for | Days/wk Weeks for | Days/wk Weeks for

Starting date: Year Month Day

4) TOTAL PERMANENT DISABILITY (if any)

In your opinion, does the employee exhibit any total permanent disability which prevents him or her from carrying on his or her employment? ☐ Yes ☐ No

If so, could the employee carry on other employment? ☐ Yes ☐ No

Signature of Physician

Only legally authorized physicians may sign the form (stamps not accepted). Please note that the employer is not bound by the recommendations of the signatory physician. **Any incomplete report, or any report whose content does not support the recommendations, could be refused without further notice**.

Name of physician (please print)

Permit no.

Area code Telephone no.

Area code Telephone no.

Address

Province

Postal code

Specialty (if necessary)

Signature of physician (do not use stamp)

Date: Year Month Day