1221 Barlow Trail SE
Calgary, AB T2E 6S2
Tel: (403) 569-8119
Fax: (403) 569-0196

- Employee must complete this three (3) page form in full, including the Authorization and Consent (Part C). Submit completed form to Lifemark Health by fax: (403) 569-0196 or by email: DMAdmin@lifemark.ca
- Have doctor complete the Attending Physician Statement and send to Lifemark Health by fax: (403) 569-0196

UNIVERSITY OF SASKATCHEWAN – EMPLOYEE QUESTIONNAIRE

PART A: APPLICANT INFORMATION

Employee's Name

Home Address	**City/Province**	**Postal Code**

Home Telephone Number ( )	**Cell Number** ( )	**Work Number** ( )

Sex Male ☐ Female ☐	**Date of Birth:** (mm/dd/yyyy)	**Email Address**

Job Title	**Department/College/Admin Unit**

PART B: DISABILITY INFORMATION – TO BE COMPLETED BY EMPLOYEE

Please describe the limitations of the illness or injury that is preventing you from working?

Are you receiving treatment from a physician or physicians?

If yes, has the physician or physicians set up a treatment plan? If yes, please confirm that you are following the treatment plan.

Is the illness or injury caused by your employment with University of Saskatchewan or another employer? (i.e. is there an existing WCB claim from USask or another employer?)

What was the first date you missed from work as a result of this condition(s)? (mm/dd/yyy)

Have you performed any modified work for University of Saskatchewan since the onset of your injury or illness?

☐ Yes ☐ No If yes, please describe:

Are you able to perform modified work related to your current role?

☐ Yes ☐ No

If yes to the above, please describe:

If no, please describe why you feel you are unable to participate in modified work:

Do you have an expected return to work date?

☐ Yes ☐ No If yes, please provide date: (mm/dd/yyyy)

By signing below, I confirm that the information in this form and any other verbal or written statement I provide in the future is true and complete to the best of my knowledge. I understand that my claim may be denied or terminated as a result of providing false, incomplete, or misleading information.

Name	**Date** (mm/dd/yyyy)

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PART C: AUTHORIZATION AND CONSENT

AUTHORIZATION AND CONSENT FOR THE COLLECTION, USE AND DISCLOSURE OF MEDICAL AND PERSONAL INFORMATION

I,_____hereby agree to release to Lifemark Health all necessary medical and personal information related to my current illness/injury/condition related to this current application and limited to information sought in the Attending Physicians Statement for, or receipt of, disability benefits from The University.

I acknowledge and understand that where necessary this current medical and personal information shall only be used to determine my medical and functional impairment, and this information (regarding functional status, workplace accommodation, and level of disability) may be provided by Lifemark Health to Wellness Resources (at the University) to assist in the determination of my qualification for, and/or continued entitlement to disability benefits. This current information may also be used for return to work planning when medically appropriate.

I acknowledge and understand that I may withdraw consent to the collection, use and disclosure of my medical and personal information by providing written notice to Lifemark Health at any time. I further acknowledge and understand that without my current medical and personal information and related supporting documentation, my qualification for disability benefits cannot be assessed and therefore withholding or withdrawing my consent to the collection, use, and disclosure of my current medical and personal health information may adversely impact my eligibility for, and continued entitlement to disability benefits.

I agree that a photocopy, facsimile or electronic copy of this consent shall be as valid as the original document.

Dated at_____,_____on_____20_____
City Prov. Month / Day

_____ _____
Employee Name Employee's Signature

_____ _____
Witness Name Witness Signature

lifemark
WORKPLACE HEALTH & WELLNESS

AUTHORIZATION AND CONSENT FOR EMAIL COMMUNICATION

Lifemark Health offers the opportunity to communicate by email. This service is offered to assist with arranging contact with your Lifemark Health Case Manager, confirm appointment dates and forwarding formal correspondence regarding the status of your claim. It will not be used as a means to replace telephone contact for functional information and medical updates.

Lifemark Health will consider and treat electronic communication with the same degree of privacy and confidentiality as written medical records.

The following summarizes some of the associated risks and responsibilities associated with electronic communication:

- *Standard email communication is not a guaranteed secure means of communication*
- *If emailing you at your employee email address, your employer may have a legal right to inspect and keep any emails that pass through their system*
- *Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties if information is subpoenaed.*

Please check and acknowledge either of the following:

☐ I,_____, understand the potential risks associated
(Print Name)
with electronic communication and hereby consent to have electronic communication with Lifemark Health. I agree and release Lifemark Health from any liability that may occur due to electronic communication.

I authorize Lifemark Health to communicate with me to the following email address:

_____
(Email Address)

I understand that I may revoke my consent to communicate electronically at any time by notifying Lifemark Health in writing. **OR**

☐ I,_____, ***do <u>not</u> wish*** to have any electronic
(Print Name)
communication from Lifemark Health.

_____ _____
Employee Name Date