3 Continuation of Attending Physician's Statement for absences that may be greater than 4 weeks

History – Has the patient been treated for this condition in the past? ☐ Yes ☐ No If Yes, date(s) (dd-mm-yyyy) – –

Visits – Frequency of visits ☐ Weekly ☒ Monthly ☒ Other Bi-weekly

Symptoms – Describe current symptoms, severity and frequency.

Investigations – **Please attach copies of all relevant:**

- **Test results/investigations (if test results are not attached, we will interpret this as tests were not performed)**
- **Consultation reports**

Are tests/investigations pending? ☐ **Yes** ☐ **No** **If Yes, expected date of receipt (dd-mm-yyyy)** – –

If consultation reports are not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist Specialty Date of visit (dd-mm-yyyy) – –

Restrictions and limitations – Based on your findings and clinical observations, please describe your patient's current cognitive and/or physical restrictions and limitations.

Complications and other condition(s) – Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period.

Compliance to treatment – To your knowledge, is the patient following the recommended treatment program? ☒ Yes ☒ No

Competency – In your opinion, is your patient competent to manage his/her own affairs? ☒ Yes ☐ No

Prognosis – Please provide the prognosis for recovery (if not completed on page 1)

4 Attending Physician's acknowledgement

I acknowledge that the information in this Statement will be kept in a group disability benefits file with Sun Life Assurance Company of Canada and may be disclosed to the patient and/or those authorized by him/her unless I notify you in writing that there is a significant likelihood that such disclosure would result in a substantial adverse effect on the health of the patient or in harm to a third party.

Last name of attending physician (please print)	First name	Certified specialist	Physician's stamp

Address

Telephone number	Fax number
111 – 11 – 1111	222 – 222 – 2122

Physician's signature	Date signed (dd-mm-yyyy)
X	– –

NOTE: The patient is responsible for any charge made for the completion of this form.

Canadian Life and Health Insurance Association Inc. Association canadienne des compagnies d'assurances de personnes inc.

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