ACCIDENT BENEFITS MEDICAL REPORT

(For use in provinces except Alberta, Ontario, and Nova Scotia; In Quebec, used with Q.E.F. 34 & 4-34)

Your patient has completed the attached authorization. Your co-operation in completing and returning this form will be appreciated.		
PATIENT		Claim No./Policy No.
AUTO ACCIDENT DATE	Date First Treated	Date Last Seen
OCCUPATION		
NATURE OF INJURIES		
TREATMENT AND SURGICAL PROCEDURES (including dates)		
PROVISIONAL PROGNOSIS		
To the best of my knowledge the patient has been unable to perform the essential duties of his/her occupation. From To		
To the best of my knowledge the patient has been able to perform some of the essential duties of his/her occupation. From To		
Were the injuries sustained in this accident the sole cause of complaints? ☐ Yes ☐ No If "no", explain:		
Have you completed any other medical reports relating to this injury? ☐ Yes ☐ No If "yes", to whom?		
OTHER COMMENTS		
DATE RETURN TO WORK	Provisional	Definite

DOCTOR	Name (Please Print)	
	Signature	Date