

**PAID ABSENCE CLAIM FORM
MILITARY AVIATION TRAINING EMPLOYEES**

PART A – TO BE COMPLETED BY EMPLOYEE

Employee's Last Name:	Employee's First Name:	Badge Number:
Home Address:	Work Number:	Home Number:
Position:		
Department:	Location:	
Were you hospitalized because of this health condition? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, provide dates of hospitalization: _____ to _____	
Did you present any claim to one of the following organizations? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, check: CSST <input type="checkbox"/> SAAQ <input type="checkbox"/> QPP <input type="checkbox"/> HRDC <input type="checkbox"/> WCB <input type="checkbox"/> CPP <input type="checkbox"/> Other <input type="checkbox"/> _____	
Is the disability due to a workplace accident? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, did you fill out an accident report? Yes <input type="checkbox"/> No <input type="checkbox"/> If no, please fill out an accident report as soon as possible.	
Name of Physician:		
Address of Physician:		Phone Number:
I request the physician to complete the information listed below and authorize its release to my employer.		
Employee's Signature:		Date:

PART B – TO BE COMPLETED BY EMPLOYEE’S PHYSICIAN

Date of first visit:	Date that disability or illness began:
Will complications or factors prolong the disability or illness? Yes <input type="checkbox"/> No <input type="checkbox"/>	If yes, please explain:
Date of next physician’s visit:	Estimated date of return to work:
In my opinion, the above named person is incapable, by reason of illness or injury, of working at his/her normal occupation. Yes <input type="checkbox"/> No <input type="checkbox"/>	
A person authorized to practice medicine in the province of: _____	
Physician’s signature:	Date: