



## VSTA SALARY INDEMNITY FUND SICKNESS OR ACCIDENT CLAIM FORM

### DECLARATION OF CLAIMANT

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ Postal Code \_\_\_\_\_

The exact nature of my illness or injury was as follows:

\_\_\_\_\_  
\_\_\_\_\_

in consequence of which I was absent from teaching from: \_\_\_\_\_ 20\_\_ to \_\_\_\_\_ 20\_\_  
(inclusive). This is a total of \_\_\_\_\_ days absence (school days only).

My absence from teaching duty:

(a) was terminated on \_\_\_\_\_ 20\_\_ OR (b) is still continuing Yes \_\_\_ No \_\_\_

In making this application for benefits, I hereby authorize the Vancouver School Board to release to the VSTA-SIF Committee such information that is necessary to process my claim.

\_\_\_\_\_  
Signature of Claimant

\_\_\_\_\_  
School

Social Insurance No. \_\_\_\_\_

Date \_\_\_\_\_

*The Salary Indemnity Fund Committee, by furnishing this form and investigating the claim, shall not be held to admit validity of any claim or waive the breach of any condition of the By-Laws of the Federation governing the Salary Indemnity Fund.*

*Completed Claim and Medical Forms **to be returned to the VSTA SIF Committee** at 2915 Commercial Drive, Vancouver, BC V5N 4C8.*



# Vancouver Secondary Teachers' Association

VSTA

2915 Commercial Drive, Vancouver, BC V5N 4C8 tel: 604-873-5570 fax: 604-873-3916 www.vstaweb.ca

## VSTA SALARY INDEMNITY FUND SICKNESS OR ACCIDENT CLAIM FORM

Please Print

### CERTIFICATE OF ATTENDING PHYSICIAN

#### Sickness or Accident Claim

Patient's Name \_\_\_\_\_ SIN \_\_\_\_\_ Age \_\_\_\_\_

School \_\_\_\_\_

I hereby authorize the release of claims' administrator of the Salary Indemnity Fund, rehabilitation service provided and their agents, and to independent medical providers, or any information requested in respect of this claim.

Date \_\_\_\_\_ Patient's Signature \_\_\_\_\_

**I HEREBY CERTIFY THAT** \_\_\_\_\_

is being treated by me for (state in detail the nature of illness or injury) \_\_\_\_\_

\_\_\_\_\_ and such illness or injury is/was solely responsible for the patient's absence from teaching duty and is of sufficient severity to warrant absence from teaching duties.

This patient has been in my care since \_\_\_\_\_

from \_\_\_\_\_, 20\_\_\_\_ to \_\_\_\_\_, 20\_\_\_\_

When did the illness begin, or accident occur? \_\_\_\_\_

From what date was this patient unable to perform teaching duties? \_\_\_\_\_

Is there a previous history of this illness?  Yes  No

If yes, give details \_\_\_\_\_

In case of pregnancy, fill in the following information:

Date of expected birth \_\_\_\_\_ Date of actual birth \_\_\_\_\_

Were there any medical complications associated with this pregnancy?  Yes  No

If yes, please explain \_\_\_\_\_

In the case of a surgical procedure, fill in the following information:

On the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, the following surgery was performed

\_\_\_\_\_

Were there any medical complications? \_\_\_\_\_

Is the patient's health such that he/she is now able to return to teaching?

\_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ Part-time % \_\_\_\_\_

If no, on what date do you anticipate the patient's health will permit teaching?

\_\_\_\_\_, 20\_\_\_\_\_

Dated \_\_\_\_\_, 20\_\_\_\_\_

\_\_\_\_\_  
Attending Physician – please print

\_\_\_\_\_  
Address

\_\_\_\_\_  
Telephone No.

\_\_\_\_\_  
Signature of Attending Physician

Completed form to be returned to:

VSTA-SIF Committee  
2915 Commercial Drive  
Vancouver, BC V5N 4C8