



DOCTOR'S FORM (SB-2)

The following employee has applied for compensation benefits under the terms of our Union Sick Bank. In order for the Union to determine the merit of this claim, would you please answer the following questions (**PLEASE PRINT**):

Name of Employee: _____

1. **Nature of Illness:** _____

2. **Expected date of return to work:** _____

3. **Is illness likely to last longer than thirty (30) days?** Yes No

4. **Is this a third party claim(ICBC, WBC, LTD EI)?** Yes No
 If Yes, specify: _____

 Doctor's Signature

 Date

Doctor's Name(Please PRINT), Address, phone#: _____

I authorize Doctor _____ to complete this form.

 Employee's Signature

 Date

PLEASE RETURN THIS FORM TO WITH YOUR SICK BANK APPLICATION

YOUR UNION, YOUR VOICE.