

Return this form to:

# Disability Certificate (OCF-3)

Use this form for accidents that occur on or after November 1, 1996.

<b>Claim Number:</b>	
<b>Policy Number:</b>	
<b>Date of Accident:</b> (YYYYMMDD)	

Use this form for accidents that occur on or after November 1, 1996. If your insurance company asks you to complete this form, fill out Parts 1 to 3 and give the form to your **health practitioner (chiropractor, dentist, nurse practitioner, occupational therapist, optometrist, physician, physiotherapist, psychologist, speech language pathologist)**. After your health practitioner has explained your accident-related injury to you, sign Part 4. Your health practitioner will complete the rest of the form, based on his/her most recent assessment, and return it to the insurance company.

Only an authorized health practitioner can complete this form. The health practitioner's opinion will be relied upon by people who review the certificate to make important decisions. Accordingly, it is necessary to be accurate and complete. Please print clearly and provide all information requested. This form may not be materially altered.

Confidentiality: Collection, use and disclosure of this information is subject to all applicable privacy legislation.

<b>Part 1 Applicant Information</b>  To be completed by the applicant	Date Of Birth (YYYYMMDD)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Number	Extension		
	Last Name		First Name			
	Middle Name	E-mail (optional)				
	Address					
	City	Province	Postal Code			
	Are you currently working? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, when was the last date that you worked?			Year	Month	Day
	Were you working at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what type of work were you doing?					
	Did you work at least 26 weeks of the previous 52 weeks preceding the accident or were you receiving Employment Insurance during that time? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Were you receiving Employment Insurance at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Were you the primary caregiver for anyone you lived with at the time of the accident? (see Part 6 for definition) <input type="checkbox"/> Yes <input type="checkbox"/> No					
Were you enrolled in an education program (elementary, secondary, post-secondary or continuing education) at the time of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No						



**To the Health Practitioner:**

Please complete the following information based on your most recent examination of the applicant named in Part 1 and return the form to the insurance company listed in Part 2. **Please print clearly.**

**Part 5  
Injury and  
Sequelae  
Information**

This part and the rest of this form must be completed by your Health Practitioner

Provide a description (list most significant first) and associated ICD-10-CA+ code for any injuries and sequelae that are the direct result of the automobile accident. (Refer to the User manual at <a href="http://www.hcaiinfo.ca">www.hcaiinfo.ca</a> for ICD-10-CA coding information.)	
Description	Code

**Part 6  
Disability  
Tests and  
Information**

To be completed by the health practitioner

Date symptoms first appeared: ____/____/____ (YYYYMMDD) Date of most recent examination: ____/____/____ (YYYYMMDD) Date of first post-accident examination: ____/____/____ (YYYYMMDD)		
Is the applicant substantially unable to perform the essential tasks of his/her employment at the time of the accident as a result of and within 104 weeks of the accident? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
Can the applicant return to work on modified hours and/or duties? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A		
If yes, please explain:		
Does the applicant suffer a complete inability to carry on a normal life? (i.e., Has the applicant sustained an impairment that continuously prevents the person from engaging in substantially all of the activities in which the person ordinarily engaged before the accident?) If yes, please explain:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
As the Primary Caregiver, does the applicant suffer a substantial inability to engage in the caregiving activities in which he/she engaged at the time of the accident? (Primary Caregiver means that, at the time of the accident, the applicant was residing with a person in need of care and the applicant was the primary caregiver for the person in need of care and did not receive any remuneration for engaging in caregiver activities.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Is the applicant, as a result of the accident, unable to continue in an elementary, secondary, post-secondary or continuing education program that the applicant was enrolled in at the time of the accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does the applicant suffer a substantial inability to perform the housekeeping and home maintenance services that he/she normally performed before the accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<p>If you responded 'Yes' to any disability test above, what is the anticipated duration?</p>	<input type="checkbox"/> 1-4 weeks <input type="checkbox"/> 5-8 weeks <input type="checkbox"/> 9-12 weeks <input type="checkbox"/> more than 12 weeks
<p>If you responded Anticipated Duration 'more than 12 weeks' to any disability test above, please explain why the task/activity limitations are likely to persist beyond 12 weeks.</p> <p>Please explain:</p>	

**Part 7  
Further  
Investigations  
or  
Consultations**

<p>a) Have there been any examinations, investigations, or consultations not previously reported by you?  <input type="checkbox"/> No    <input type="checkbox"/> Yes (please specify findings and results)</p> <p>b) Are further examinations, investigations or consultations contemplated or required?  <input type="checkbox"/> No    <input type="checkbox"/> Yes (please specify)</p>
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**Part 8  
Prior and  
Concurrent  
Conditions**

<p>a) Prior to the accident, did the applicant have any disease, condition or injury that affected his/her ability to perform the activities listed in Part 6?  <input type="checkbox"/> No    <input type="checkbox"/> Unknown    <input type="checkbox"/> Yes (please explain)</p> <p>If yes, is the applicant currently receiving any disability benefits for the pre-existing disease, condition or injury?  <input type="checkbox"/> No    <input type="checkbox"/> Unknown    <input type="checkbox"/> Yes (please explain)</p> <p>If you treated the applicant for similar conditions prior to the accident, please describe (include date of onset, any subsequent interventions, and status at the time of the accident).</p>
<p>b) Since the automobile accident, has the applicant developed any disease, condition or injury, not related to the accident, that could affect his/her disability?  <input type="checkbox"/> No    <input type="checkbox"/> Unknown    <input type="checkbox"/> Yes (please explain)</p>

**Part 9  
Medications**

- a) Please list any medications (including dosage and frequency) that the applicant is currently taking for injuries related to the automobile accident.  
Were these medications prescribed by you?  No  Yes
- b) Please list any medications (including dosage and frequency) that the applicant is currently taking as a result of prior or concurrent conditions identified in Part 8.  
Were these medications prescribed by you?  No  Yes

**Part 10  
Health  
Practitioner  
Signature**

Name of Health Practitioner		College Registration Number		<b>You are a:</b> <input type="checkbox"/> Chiropractor <input type="checkbox"/> Dentist <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Occupational Therapist <input type="checkbox"/> Optometrist <input type="checkbox"/> Physician <input type="checkbox"/> Physiotherapist <input type="checkbox"/> Psychologist <input type="checkbox"/> Speech-Language Pathologist
Facility Name (if applicable)		AISI Facility Number (if applicable)		
Address				
City		Province	Postal Code	
Telephone Number	Extension	Fax Number		
Email Address				
<p><b>I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT.</b></p> <p><b>I UNDERSTAND THAT IT IS AN OFFENCE UNDER THE INSURANCE ACT</b> to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. Regulated sectors may be subject to an examination or inquiry about matters in connection with a licence and or unfair or deceptive act or practice. Non-compliance with applicable regulations may result in enforcement actions ranging from an administrative monetary penalty to prosecution under the Provincial Offences Act.</p> <p><b>I FURTHER UNDERSTAND THAT IT IS AN OFFENCE UNDER THE FEDERAL CRIMINAL CODE</b> for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company. This information will be used for processing payments of claims; identifying and analysing the nature, effects and costs of goods and services that are provided to automobile accident victims, by health care providers; and <b>PREVENTING, DETECTING AND SUPPRESSING FRAUD.</b></p>				
Name of Health Practitioner (please print)		Signature of Health Practitioner		Date (YYYYMMDD)

Note: The fee for completing this certificate is not a health care benefit of the Ontario Ministry of Health and Long-Term Care. This fee should be billed to the insurer directly.