

Return this form to:

Disability Certificate (OCF-3)

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

Claim Number:	
Policy Number:	
Date of Accident: (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.

If this disability certificate is being completed to support your application for accident benefits, it must be completed by your health practitioner no earlier than 10 business days of the date of your application. If your insurer has requested a new disability certificate, it must be provided within 15 business days of this request. 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.

Part 1 Applicant Information 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	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?				
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					

Part 2 Insurance Company Information To be completed by the applicant	Name of Insurance Company	City or Town of Branch Office (if applicable)			
	Name of Insurance Company Representative		E-mail (optional)		
	Telephone		Fax		
	Name of Policy Holder same as: <input type="checkbox"/> Applicant OR	Policy Holder Last Name		Policy Holder First Name	

**Part 3
Accident
Description**

To be completed
by the applicant

Give a brief description of the accident and what happened to you. Please describe any injuries you sustained as a direct result of the accident.

additional sheets attached

**Part 4
Applicant
Signature**

I authorize my treating health professional to collect, use and disclose to my insurer or to a health professional, social worker, or rehabilitation expert properly identified by my insurer to conduct an examination, only such information relating to my health condition and treatment received as a result of the automobile accident and any pre-existing or subsequently occurring health conditions that may be barriers to my recovery as a result of the automobile accident, as is reasonably required for the purpose of providing treatment and determining my eligibility for benefits. I authorize the health practitioner who completes this form to contact my employer, if this is necessary, to confirm the essential tasks of my employment and the nature and extent of any available work with modified hours or duties.

This authorization does not apply to a consultation between my health care provider and the insurer's health professional conducting an examination. Separate express consent is required for this consultation. This consent should be in writing.

I certify that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.

Name of Applicant or Substitute Decision Maker (please print)	Signature of Applicant or Substitute Decision Maker	Date (YYYYMMDD)
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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 www.hcaiinfo.ca for ICD-10-CA coding information.)

Description	Code

**Part 8
Prior and
Concurrent
Conditions**

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?
 No Unknown Yes (please explain)

If yes, is the applicant currently receiving any disability benefits for the pre-existing disease, condition or injury?
 No Unknown Yes (please explain)

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).

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?
 No Unknown Yes (please explain)

**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		You are a: <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				
I confirm that the information provided is true and correct. I understand that it is an offence under the Insurance Act to knowingly make a false or misleading statement or representation to an insurer under a contract of insurance. I further understand that it is an offence under the federal Criminal Code for anyone, by deceit, falsehood, or other dishonest act, to defraud or attempt to defraud an insurance company.				
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.