SICK LEAVE PLAN

EMPLOYEE'S STATEMENT *(To Be Completed By Employee / Fax (250) 364-4304)*

Teck

PART 1

Employee Name:	**Empl #:**	
Address:	Phone #: ( )	**Shift:**
	Date of Birth:	
	Occupation:	
	Supervisor:	

PART 2

A	Is Disability due to *(please circle one)*:	HOSPITALIZATION	PROCEDURE	SICKNESS	ACCIDENT
	Date first unable to work due to disability:		Expected return to work date:		
	Has or will a claim be filed with the Worksafe BC?			YES	NO
B	Attending Physician:			Date of First Visit:	
	Hospitalized?	YES	NO	Admitting Physician:	
	Admission Date:			Discharge Date:	
C	Were you working for another employer during the period claimed?			YES	NO
	If yes, give details including source and amount of benefit:				

I declare all the information I have given on this report is true and correct. I understand to work and earn income while receiving Basic Sick Leave Benefits without advising Claims and Disability Management at Teck Metals Ltd., Trail Operations is not permitted.

Employee Signature:	***Date:***

FOR INTERNAL USE ONLY *(Do Not Write Below This Line)*			
BSL #	Continuation? Y / N	APSS Sent?	Physician:
Wage:	LSW:	VAC:	AIP? Y / N
Claims in 12 months:		Waiting Period:	
BSL 1st Payment:		BSL Last Payment:	
01 ACTIVE END		WSBC Undertaking Signed?	
		ICBC Undertaking Signed?	
09 SICK LEAVE		LTD Undertaking Signed?	
20 SWB		Disability Insurance Forms?	

CLAIM CLOSED			
Date RTW:	Duties:	REG	C-86
# Shifts Missed:	BSL Top-Up?		

SICK LEAVE PLAN

PRIVATE PHYSICIAN REPORT TO EMPLOYER (Fax to 250-364-4304)

Teck

Employee Name:	Empl #:

I authorize physicians, hospitals and insurers to release information with respect to the illness/injury for which I have applied for basic sick leave benefits. This authorization is only for information relevant to the claim and I understand that Teck Metals Ltd. will keep such information confidential solely for the purposes of the claim.

Employee Signature:	***Date:***

To Be Completed By Private Physician

What medical restrictions/limitations are there that disable the employee from doing their normal job:

Is Injury/Sickness Work Related?	YES	NO

Date of Injury/Sickness for this claim:

Date of First Visit for this claim:	Date of Latest Visit/Treatment for this claim:
Date Admitted to Hospital:	Date Discharged From Hospital:

Is the employee undergoing therapy or in receipt of medications that will impact on the employees ability to work ?(eg. therapy, medications, etc)

Current Medical Status ***(Please complete one of the following)***

	Anticipated Return to Work Date	*Date:*
	Recovered-may return to work with no limitations.	*Date:*
	Partially Recovered-may return to work with the following limitations:	*Date:*
	These limitations are in effect until:	*Date:*
	or until employee is reassessed on:	*Date:*
	Totally Incapacitated-employee will be re-assessed on:	*Date:*
	Target date for return to work:	*Date:*

Physician's Signature:	Date:
Physician's Name *(please print)*:	Address: